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The Ohio State MEDICAL JOURNAL

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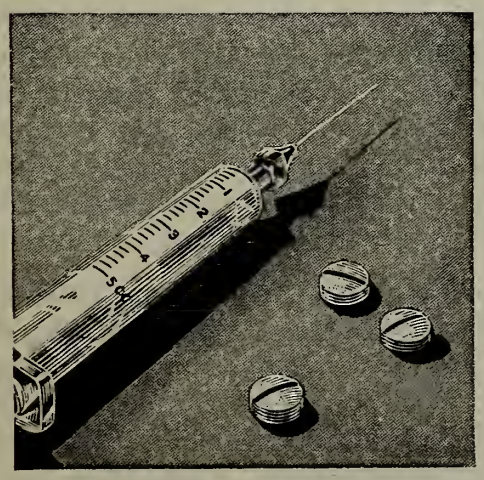
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Neurosurgical Nursing, by Walter G. Haynes, M. D., and Mary McGuire, R. N., ($3.50. *W. B. Saunders Co., Philadelphia, Pa.)*, presents in a compact form the information needed for this field of specialization in nursing. It comes from a student of Eric Oldberg.

The Human Colon; an experimental study based on direct observation of four fistulous subjects, by William J. Grace, Stweart Wolf and Harold Wolff, ($7.50. *Paul B. Hoeber, 49 E. 33rd St., New York 16, N. Y.)*. This unusual book reports on a ten year study of the effect of emotion on the colonic mucosa. The conclusions seem too fantastic to be true. More in line with the exaggeration of much of modern psychosomatic medicine than with the experience of reliable clinicians, yet one cannot question the integrity of the authors in view of the earlier work of Wolf and Wolff.

Diet Prevents Polio, by Benjamin P. Sandler, M. D., ($_____. *The Lee Foundation for Nutritional Research, Milwaukee, Wis.)*, has for its purpose the showing of how one may fortify the body through diet and thus prevent infection. The author offers evidence that the maintenance of a normal level of blood sugar will prevent the invasion of the body's tissues by polio virus. Since the maintenance of a normal blood sugar level is fundamentally dependent on the food we eat, the manner of prevention in this disease especially becomes a matter of diet.

The monkey has a low blood sugar and is very susceptible to polio virus; the rabbit has a high blood sugar and is resistant to the same virus. If the rabbit is made hypoglycemic it too becomes susceptible. These facts the author correlates with violent exercise, swimming and chilling, and the hot weather with its excessive use of sweet beverages, ice cream and other sweets. The author conducted campaigns in 1948 and 1949 against the use of sweets during the season in North Carolina and apparently made a significant dent on the incidence of the disease as compared with his controls.

Plasma Proteins—Vol. II, Symposia on Nutrition, edited by John B. Youmans, M. D., of the Robert Gould Research Foundation, Inc., ($6.50. *C. C. Thomas, Springfield, Ill.)*. In addition to the more limited clinical aspects of the plasma proteins as represented by hypoproteinemia, nutritional edema and similar abnormalities, a consideration of the plasma proteins expands naturally in this volume to consider such broad aspects of human physiology as the essential character of amino acids, the function of certain vitamins, the riddle of protein metabolism and the detailed and intimate behavior of proteins in complex physical and chemical systems.

Ohio may well be proud of this Cincinnati Foundation and the work in health and nutrition which it is supporting.

Understanding Your Migraine Headache, by Caro W. Lippman, M. D., and Margaret Lippman, ($2.50. *Greenberg, Publisher, Inc., New York 22, N. Y.)*. This book is directed at the 12 million sufferers from the one sided sick headache. It treats of the migraine symptoms as what they are—personality traits. Great emphasis is made of what is called migrainoids. The chapters are devoted to such subjects as blind spots, acute sensitivity, hallucinations, recurrent dreams, mental confusion, compulsions, night owls, personality patterns, habits, marriage, and treatment. The book is by a well trained and well known neurologist in San Francisco and his migrainous wife.

Child Psychology, by Horace B. English, ($4.50. *Henry Holt & Co., Inc., 257 Fourth Ave., New York 10, N. Y.)*, is the product on the part of an Ohio State University professor on a concern for the welfare of children and a conviction that modern psychology has much to offer for promoting that welfare. It deals, therefore, with what in the light of reality parents and teachers can do to help children.

Principles of Hospital Administration, A Guide to Efficient Hospital Planning and Successful Management, by John R. McGibony, M. D., ($6.00. *G. P. Putnam's Sons, New York 16, N. Y.)*. A new book on the subject for all who work in the hospital or public health field. In addition to a thorough coverage of the administration of the physical plant, the work of the clerical service is fully presented. It is a book for your professional library.

Living With Diabetes, by Edward Tolstoi, M. D., ($2.00. *Crown Publishers, Inc., 419 Fourth Ave., New York 16, N. Y.)*. The author presents his method of treatment and presents the evidence and background of it. Apart from the regular daily dose of insulin the patient under this plan lives as normally as the non-diabetic.

Problems of Aging—The Transactions of the Fourteenth Conference, edited by N. W. Shock, ($3.00. *Josiah Macy, Jr. Foundation, 565 Park Avenue, New York 21, N. Y.)*. It contains four important discussions: Biology and Medicine, led by John Esben Kirk; Sociology, Psychology, Education, and Religion, Robert J. Havighurst;

Economics, Employment, and Welfare, Wilbur J. Cohen; Medical Services, Hygiene, and Housing, Joseph W. Mountin.

Your Hair, Its Health, Beauty and Growth, by Herman Goodman, M. D., ($2.95. *Emerson Books, Inc., 251 West 19th St., New York, N. Y.).* Interest in one's hair is universal. When clothing was adopted by Man, he left exposed only the skin on his face and hands and the hair of his scalp. The author of this book is a distinguished dermatologist best known for his appraisal of cosmetics and for his contributions to the industry. This book, therefore, is practical with no false promises and no extravagant claims. The author also brings to its writing his years of experience in popular presentations of medical subjects.

The Physicians, A Novel, by Hazel Lin, ($3.00. *The John Day Co., 210 Madison Ave., New York, N. Y.),* is the story of medicine showing the difference between Chinese medicine and the new medicine of the Western World, written by a Chinese woman physician successfully practicing in the United States. Parts of it are no doubt autobiographical. Nevertheless, it is a dramatic story told with warm humor and a deep understanding of human nature.

Insanity Laws, by William R. Dittmar, Ph. D., (Cloth, 2.00; paper, $1.00. *Oceana Publications, 43 West 16th St., New York 11, N. Y.),* is the thirtieth of the Legal Almanac Series which brings the law on various subjects to you in non-technical language. At the same time they give the individual's rights and responsibilities.

The Present Status of Antibiotic Therapy, with Particular Reference to Chloramphenicol, Aureomycin and Terramycin, by Francis G. Blake, M. D., (90¢. American Lecture Series No. 137. *C. C. Thomas, Springfield, Ill.),* is the 1951 Augustus B. Wadsworth Lecture. The handy little monograph covers the remarkable recent advances in the treatment of infectious diseases.

Helping Parents Understand the Exceptional Child, (Apply. *Child Research Clinic, The Woods Schools, Langhorne, Pennsylvania),* contains four addresses given at the 1952 conference on "Helping Parents Understand the Exceptional Child." The subjects were: The Emotional Quandaries of the Exceptional Child; His Psychology; How School Can Help; The Growth of His Social Responsibility and His Parents' Understanding.

Dictation for the Medical Secretary (with previews in Gregg shorthand simplified), by Kathleen Berger and Edward E. Byers, ($3.00. *Gregg Publishing Co., New York 18, N. Y.),* is designed as a text to meet the need for a shorthand vocabulary of the principal branches of medicine through the medium of carefully prepared and compiled dictation material.

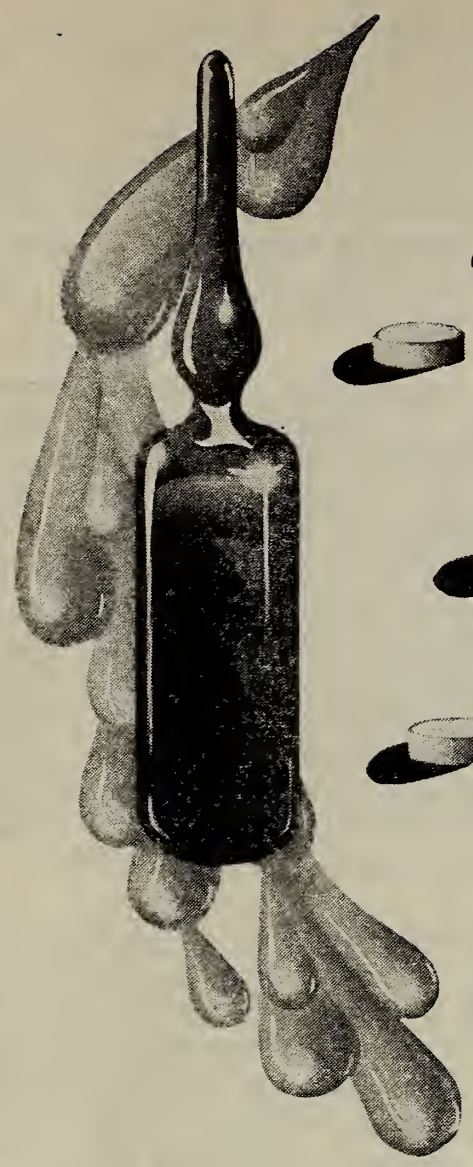
The Technique of Clear Writing, by Robert Gunning, ($3.50. *McGraw-Hill Book Co., Inc., 330 West 42nd. St., New York, N. Y.),* is the essence of what the Robert Gunning Associates have been teaching thousands of writers since they were founded in 1944 to do readability counseling. The book which this Columbus, Ohio, expert has written is a must for everyone who attempts to write.

The Organization of Hospital Nursing Services, edited by Charlotte Seyffer, R. N., ($2.50. *Catholic University of America Press, 620 Michigan Ave., N. E., Washington 17, D. C.),* is the Proceedings of the workshop on the subject conducted by the University a year ago. The evaluation of the nursing service programs is a great administrative responsibility that is an ever recurring problem. To the outsider it would seem that these services with the help of our inflated dollars is definitely pricing itself out of the market. Even a Federal government bent on bankruptcy cannot assume the cost for long. Here we find a careful analysis of the problem as of 1951.

Medical Milestones, by Henry J. L. Merriott, M. D., foreword by Sir Alexander Fleming; ($3.50. *Williams & Wilkins Co., Baltimore 2, Md.).* In this era of rapid medical advancement more than ever truth has become stranger than fiction. Early antibiotics—and the later ones, blood clotting, anti-thyroid drugs, hormones and enzymes, the Rh factor, British anti-lewisite, and much other information about the new drugs in medicine written in a charming manner by one of the physicians at St. Mary's Hospital in London.

The Merck Index, ($8.00. Sixth Edition. *Merck & Co., Rahway, N. J.),* provides as did the previous five editions a concise, comprehensive and readable encyclopedia of chemicals and drugs for the chemist, pharmacist, physician, and members of the allied professions. It contains 8,000 descriptions of individual substances in addition to 2900 new monographs and revision of those monographs retained from earlier editions. The medical and veterinary uses have been rewritten for all and brought up to date.

Psychology, Religion and Healing, by Leslie D. Weatherhead, ($5.00. *Abingdon-Cokesbury Press, 810 Broadway, Nashville 2, Tenn.).* Written by one of England's foremost workers in the field of pastoral psychology, this book is a critical study of all the non-physical methods of healing with an examination of the principles underlying them and the techniques employed to express them, together with some conclusions regarding further investigation and action in this field. Your reviewer has enjoyed his comments on Freud's ignorance of Christianity.



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Quinidine in the Treatment of Chronic Auricular Fibrillation

G. S. BELAVAL, M. D., and H. J. BARKER, M. D.

EVER since Frey introduced quinidine in 1918 as a valuable agent in the treatment of auricular fibrillation, considerable controversy has arisen regarding the merits of the drug in this disorder. Similarly conflicting opinions have been expressed concerning the hazards and the advantages of the reestablishment of a normal sinus rhythm.

For many years it was the prevailing thought among medical men that auricular fibrillation was but the natural sequela, frequently the terminal event, in the life cycle of a failing myocardium and that it played an insignificant role in the final outcome of such a disease process.

There has been enough clinical and experimental evidence presented in the last few years to support the modern concept that persistent, long, standing fibrillation of the auricles is not an innocuous mechanism, despite the fact that some patients live apparently comfortably for many years with a ventricular rate well controlled with digitalis.

In animal studies it has been shown that the cardiac output is diminished by about 40 per cent when auricular fibrillation is established.[1] Several workers [2, 3] have presented indubitable evidence of a decrease in blood flow with the onset of this arrythmia. Blumgart's[4] investigation is deserving of serious thought. He concluded that in patients with atrial fibrillation the increase in ventricular rate after exercise is greater and its return to the previous resting state is slower than in individuals with a sinus rhythm.

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Submitted June 18, 1952.

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Several reports[5, 6] in the literature have demonstrated that cardiac enlargement and congestive heart failure can occur in patients with this dysfunction in the absence of any evidence of organic heart disease, and that such a decompensation can be reversed with restoration of sinus rhythm.

Fahr[7] mentioned several cases of athletes performing well in competitive endeavors despite the presence of a mitral stenosis. Promptly after auricular fibrillation was established, however, these same individuals developed signs of cardiac decompensation and thereafter became chronic invalids who could at best carry out duties entailing only a minimum of exertion.

Another of the dreaded and grave dangers of this arrythmia is pulmonary and systemic embolization. Auricular fibrillation is usually noted in the vast majority of instances of embolism occurring in the presence of mitral stenosis. According to Laws, Levine[8] and Lewis et al.,[9] 10 to 20 per cent of all deaths in rheumatic heart disease result from embolism. Daley, Mattingly and co-workers[10] recently reported that of 194 patients with rheumatic heart diseases complicated by systemic embolism, 174 or 90 per cent

had atrial fibrillation. By simple deduction one can state that roughly 10 to 20 per cent of patients succumbing from rheumatic carditis do not die from the heart disease *per se* but from the accompanying fibrillation of the auricles.

AVERAGE LIFE EXPECTANCY

Attempts to determine the average life expectancy once this disorder has been established as the predominant rhythm have yielded variable figures but in general does not compare any too favorably with the longevity of malignant disease.

White[11] estimated two to three years as the usual duration of life of a group of 173 fatal cases. Stroud, LaPlace and Reisinger[12] obtained an average of two and one-half to three years. In the experience of DeGraff and Lingg[13] the mean duration was only two years. Seventy-five per cent of their patients had expired before the third year. Frick and Kennicott[14] reported five years and eight months in a group of cases observed to exitus, while Cookson's[15] averages were five and one-fourth years for the rheumatic group and seven years for the non-rheumatic group. It is noteworthy that in the analyses of these series the various authors had several cases who survived 10 to 15 or more years, which make the short spans more significant.

OBJECTIONS TO QUINIDINE

Two of the major objections usually offered to the use of quinidine in chronic auricular fibrillation are the possibility of sudden death and embolism. Most of the authorities on this subject nowadays are convinced that these hazards have been unduly overemphasized and have prevented the use of a drug which handled rationally quite often proves life-saving.

Fahr[7] treated 500 patients with chronic auricular fibrillation at the Minneapolis General Hospital over a period of 17 years converting about 65 per cent of them to sinus rhythm without a single instance of embolism or sudden death. McMillan and Welfare[16] converted 44 patients and Sokolow[17] 93 without any instances of embolization. In restoring 119 patients to a normal mechanism Yount et al.,[18] reported two cases having emoblic episodes and noted one sudden death. However, 23 of his patients had had one or more embolizations prior to initiation of therapy. His only fatality was that of a 42 year old individual who had severe congestive heart failure. His comments concerning this case are worthy of careful scrutiny. He stated that, "One must recognize the severity of the basic cardiac lesion and realize that sudden death is common whether quinidine is used or not."

Greatly encouraged by these reports in the literature on the successful restoration of sinus rhythm in several hundred patients with chronic auricular fibrillation with such a minimum of eventualities, we decided to run our own series at St. Alexis Hospital.

FOURTEEN CASES STUDIED

We chose to proceed with our study without the theoretical assistance that frequent determinations of blood quinidine levels could give us. It was our feeling that any success we thus achieve would have added significance since it would more closely approximate the circumstances of the average practitioner or internist who usually does not have ready access to the elaborate equipment needed to run such a laboratory procedure.*

In most instances a careful determination of the vital capacity, venous pressure and circulation time of the patient as well as an accurate roentgenologic cardiac mensuration and electrocardiographic study was done prior to the institution of therapy both with the idea of determining the patient's cardiac status and establishing a baseline for future evaluation of the patient's progress.

Up to the present moment we have studied 14 unselected cases. Sinus rhythm was reestablished in 10, or 71 per cent. Five of the entire group were treated while ambulatory with only one conversion. Two of the other four were subsequently hospitalized and converted on a much smaller dosage than what they were taking while ambulant.

Quinidine was administered at four hour intervals day and night after the initial sensitivity test dose. All patients were started on a 0.2 gram schedule and the drug was progressively increased by 0.1 gram per dose every 48 to 72 hours until sinus rhythm was restored or evidences of toxcity appeared. If regular rhythm was discernible the drug was usually reduced rapidly first by prolonging the time interval from four to six hours and after 48 hours by actual decrease in the amount of each individual dose until a satisfactory maintenance program was achieved.

With one exception all cases were digitalized prior to initiation of therapy.

RESULTS OF THERAPY

As table I indicates there is considerable variability in the response to quinidine.

The age of the patient apparently plays no part in the plausibility of conversion. The older individual converts just as easily as the one in the younger age group. Age *per se* is not a contraindication to treatment with quinidine as was previously thought.

The duration of the fibrillation has apparently

*Not detracting from the obvious merits of such quantitative studies, it should be mentioned that some investigators[19] have questioned the existence of any exact correlation between the plasma and myocardial concentration of the drug and its cardiac effect.

very little effect on the response to therapy. A glance at the first case suggests that reversion does occur just as easily in the patients with the long-standing fibrillation as in those whose arrhythmia is of recent origin.

First degree A-V Block was a common finding after cessation of the ectopic rhythm. In one instance (case 10) it was unusually marked, the time interval approximating the electrical systole. With reduction of the quinidine dosage most P-R intervals reverted towards normal.

No precise correlation was recognized between the severity of the heart disease and the feasibility of conversion. There were two patients with normal circulatory dynamics one of which had no cardiac enlargement and no history of heart failure and the other manifested only a slight cardiomegaly with a past mild bout of decompensation whose arrhythmia persisted despite heavy doses of quinidine (0.6 and 0.8 gram every 4 hours). Case 6 revealed normal heart measurements, circulation time and venous pressure, yet he was a therapeutic failure displaying a troublesome conduction defect. In contrast, two of our relatively easy conversions, i. e. cases number 1 and number 10, were admitted to the hospital because of severe congestive heart failure and were successfully restored to a normal rhythm even before full compensation was attained.

The duration of therapy with quinidine required to reestablish sinus rhythm ranged from 2 to 12 days with an average of 6.7 days. The dosage in use at the time of conversion varied from 0.2 gram to 0.5 gram every four hours with an average of 0.33 gram. The total amount of quinidine used in eliminating the arrhythmia varied from 2.2 grams to 23.5 grams with an average of 10.9.

We have succeeded in maintaining five of the ten patients originally converted up to this writing with relatively small doses of the drug.

ANALYSIS OF INDIVIDUAL CASES

At this point a brief resumé of the various individual cases illustrating some of the versatile shortcomings and therapeutic problems encountered and the course followed in their management might be a fitting sequence to this presentation.

TABLE I

Case No.	Age	Duration of Fibrillation	Days of Rx	Dosage at time of Conversion	Total Amt. of Quinidine grams	Maintenance grams	P-R at Conversion	Q-T at Conversion	Q-T Ratio	Heart Size*
				grams q 4 hrs.						
1.	69	11 years	2	0.2	2.2	0.2 TID	.24	.40	1.00	+25%
2.	48	+ 6 mos.	5	0.4	6.7	0.2 qid	.20	.40	1.29	+25%
3.	70	?	7	0.4	13	----	.24	.48	1.31	?
4.	77	?	5	0.3	5.2	----	.24	.48	1.22	+25%
5.	45	+6 yrs.	12	0.5	23.5	----	.20	.52	1.40	+25%
6.	61	+16 mos.	10	**	15.7	----	.20	.40	1.00	Normal
8.	63	+ 3 mos.	3	0.2	3.2	0.2 q6hrs.	.22	.48	1.26	+25%
9.	41	?	9	0.2	14.3	0.2 qid	.22	.44	1.24	+25%
10.	65	5 yrs.	4	0.3	5.3	0.2 qid	.32	.34	1.00	+25%
13.	69	3½ yrs.	10	0.5	19.9	----	.20	.58	1.52	+25%

1 The duration of QRS interval was within normal limits in all ten cases.

2 *The heart size is expressed as a percentage deviation from its average transverse diameter, which is based on the weight and height of the patient (Ungerleider-Clark). +25% means that the measured transverse diameter is more than 25 per cent of the predicted transverse diameter of the heart for the particular height and weight.

3 **Patient not receiving quinidine at time of conversion. See analysis of Case No. 6.

Case 1, as the chart well illustrates, was particularly gratifying. Following a transient bout of nodal tachycardia, the patient converted very readily on a small dosage of quinidine on the 18th of January, at which time the drug was reduced to 0.2 gram every 6 hours. The following day further reduction to three tablets a day schedule was resorted to and on January 25th, and thereafter, one tablet was administered twice daily. Four days later on the 29th of January auricular fibrillation returned. On increasing the drug to 0.2 gram every six hours, however, sinus rhythm was re-established after about 24 hours. Her regular rhythm has persisted since then and she is being maintained on three tablets of the drug daily without any untoward effects. She has been feeling considerably better, and has increased her activities markedly without the usual distressing breathlessness. She is also very pleased with the disappearance of her annoying palpitations. It is worth noticing that she is now able to dispense with digitalis and diuretics for several weeks, whereas before the use of these measures were an essential part of her daily routine.

Case 2 displayed some rather interesting features. He was admitted after having had a transient episode of aphasia and right arm paralysis which could well have been on an embolic basis. Three days after admission and

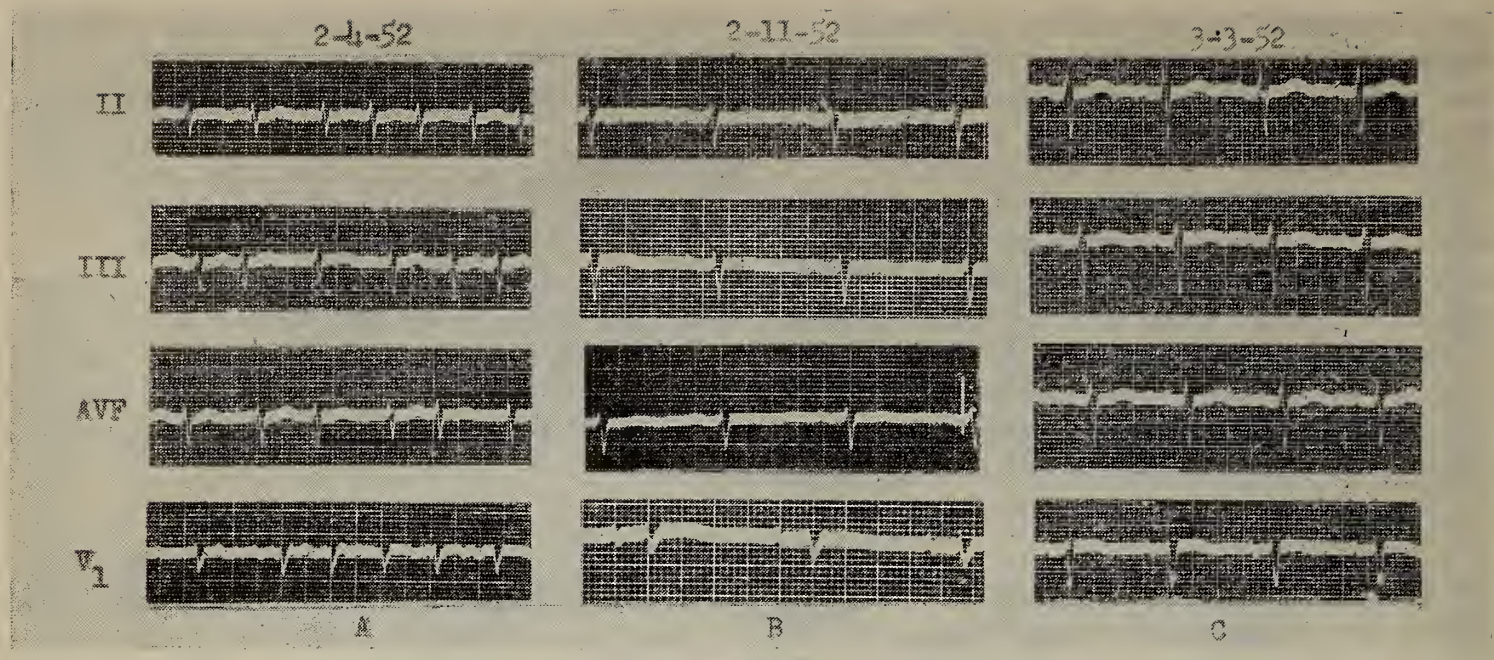


Figure I

while fibrillating rapidly he suddenly developed severe pain in the splenic area, also interpreted as another embolic manifestation. On a previous hospitalization and two days following an operative procedure this patient had a sudden intense pain in the left chest followed 48 hours later by a similar more severe one in the right chest. Pain was aggravated by deep breathing and was persistent. He subsequently developed a right pleural effusion. The possibility of this pulmonary pathology being due to dislodged auricular thrombi is certainly open to speculation. It is significant that no further embolic accidents have occurred since sinus rhythm was restored three months ago. This individual's general state of health has shown considerable improvement. The realization that he is reasonably safe from the grave dangers of future embolization has been the source of great comfort and peace of mind to him.

Case 3 was admitted with a cerebrovascular accident with a right-sided hemiplegia, severe hypertension, and advanced kidney disease. It was interesting that regular sinus rhythm reappeared despite the presence of a pronounced uremia. Her blood urea was 162 a few days prior to conversion. She was covered with urea frost at the time of her death. No postmortem examination was permitted.

Case 4 exhibited a remarkable favorable change in the form of his electrocardiogram after conversion. This is well illustrated in figure 1. (A) was taken the day before quinidine therapy was instituted and is a classical example of auricular fibrillation. Attention is called to the low voltage of the QRS complexes. (B) was recorded the day after normal rhythm was restored and (C) three weeks afterwards. The increase in the voltage of the ventricular complexes is particularly striking. Also prominent is the correction noted in the T wave patterns. This patient received no digitalis or blood transfusions. We felt that he had no cardiac decompensation and interpreted his prolonged circulation time (arm-to-tongue—30 seconds) on basis of cardiac enlargement.** We have observed similar beneficial changes in the configuration of the electrocardiograms in several of our other cases. This individual's vital capacity also revealed a very satisfactory progress increasing from 39 per cent on February 9th to 65 per cent on the 7th of March. He unfortunately expired while in the hospital. Postmortem examination revealed bilateral lobar pneumonia, advanced nephrosclerosis. Sinus rhythm persisted until his death.

Case 5 was labelled for many years as a rheumatic heart with mitral stenosis. Promptly after conversion he developed a marked oliguria with azotemia accompanied by such evidences of right ventricular failure as liver enlargement, ascites and dependent edema. No diastolic murmur was apparent. The possibility of more blood being shunted from the left ventricle to the right ventricle through a patent interventricular septal defect following a more efficient left heart was suggested. That would certainly explain the decreased renal blood flow and the increased right ventricular load. Regression of the congestive phenomena occurred with the reappearance of auricular fibrillation. This congenital anomaly now strongly suspected is substantiated by the roentgenologic studies done in this institution. Quinidine therapy was discontinued in this patient since it was concluded he would probably do better with his arrhythmia.

Case 6 furnished both of us with some very disquieting moments. He was started on the conventional quinidine routine on March 7th and was progressively increased until he was receiving 0.4 gram at the usual intervals four days afterwards. A 4:1 flutter appeared two days later. The following morning, on the 14th of March, a complete A-V dissociation developed. Both quinidine and digitoxin were immediately discontinued. On March 17th we obtained a most curious tracing showing regular sinus rhythm in all leads except the precordials. The latter, the last ones to be recorded, revealed a complete heart block. The following unusual sequence of events was then noticed on subsequent tracings secured. On March 18th regular sinus rhythm was present. On March 19th an A-V dissociation was recorded. On March 21st and 22nd normal sinus rhythm became evident once more. On March 23rd A-V dissociation was detected again. The patient has now reverted to his old mechanism of atrial fibrillation. Not infrequently

**Gernandt and Nylin[20] and Nathanson and Elek[21] showed that circulation time is more dependent on the size or volume (residual blood) of the heart than on the presence or absence of cardiac decompensation.

some of these individuals who develop a transient A-V dissociation followed by a subsequent establishment of a normal mechanism do retain their regular rhythm for a considerable time and can then be placed on a maintenance regimen.

It may be worth noting that his Q-T interval on the day of his first block was exceedingly prolonged measuring 0.60 seconds. When normal sinus activity was first noticed the latter had decreased to 0.40 seconds.

Case 8 provides a good example of why most patients with chronic fibrillation should be given a trial of quinidine therapy. This patient converted very readily on one tablet of the drug at the usual intervals while ambulatory and without appreciable discomfort. He is definitely a much improved individual requiring considerable less medication than before to maintain his compensation.

Case 9 developed a nodal tachycardia on his seventh day of therapy and while on a 0.4 gram schedule. Restoration of normal sinus rhythm was easily accomplished three days later after the dosage of the drug was reduced to half the original amount.

Case 10 presented some unique and instructive data. He submitted to the usual scheme on March 11th. On March the 13th, the electrocardiogram showed sinus rhythm with very frequent nodal extra systoles. Three days later auricular fibrillation with rapid ventricular rate recurred. Increasing the quinidine dosage merely caused an acceleration of the cardiac rate. It was then realized that our difficulty was due to improper digitalization with consequent insufficient block of the A-V node. Quinidine was temporarily discontinued and the patient given several extra injections of digitoxin. On March 20th quinidine was re-started and four days afterwards re-establishment of regular sinus rhythm was accomplished with comparative ease.

Both the last two patients were referred to their private physician who informs us that they maintained their normal mechanism up to the present moment and have shown considerable clinical improvement.

Case 13: Our last patient, Case Number 13, was converted after 10 days of therapy and while receiving 0.5 gram of quinidine. On reducing the dosage to 0.3 gram frequent nodal premature contractions appeared the following day and auricular fibrillation became re-established two days thereafter. When the drug was subsequently increased to 0.4 gram, sinus rhythm was restored within the following 24 hours. The second attempt to reduce the quinidine dosage led to a recurrence of the arrythmia. This patient obviously cannot be maintained with moderate doses and, while catalogued as a successful conversion, should be classified as a therapeutic failure. His Q-T interval incidentally was also very prolonged measuring 0.60 in some of the leads. (Average 0.58.)

NODAL ACTIVITY

Nodal activity in the form of nodal premature beats with and without retrograde conduction, short runs of premature beats, nodal tachycardia, and wandering pacemaker in which the impulse initiation site changes with, at times, signal regularity from the A-V to the S. A. node and vice versa was demonstrable in all ten of the cases converted.

In case 9 the basic rhythm changed from impure flutter to nodal tachycardia to shifting pacemaker in about 48 hours. The succeeding day the regular wandering rhythm was again detected early in the morning by electrocardiography. Sinus rhythm, however, was apparent four hours later. Case 13, in whom normal sinus mechanism was reinstated twice with subsequent reversion to atrial fibrillation each time, was unusual in that before the auricular arrythmia became evident the phenomenon of a wandering pacemaker was discernible in both occasions.

In the light of the above observations we wonder whether such nodal dynamics should perhaps be regarded as a transition stage in the process of restoration of normal rhythm from fibrillation and whether nodal tachycardia should be interpreted as a variant link in that chain of events rather than as a toxic manifestation of quinidine.

Q-T INTERVAL

All three of the patients who manifested the severest clinical or electrocardiographic evidences of toxicity exhibited very prolonged Q-T intervals. The first one (case 6) revealed an A-V dissociation and was already analyzed. The second one presented a complete typical left bundle branch block with a QRS of 0.14 seconds after a few days of treatment and while receiving 0.3 gram of quinidine every 4 hours. His Q-T interval at the time measured 0.68 seconds. He complained bitterly of precordial distress, extreme malaise and slight dyspnea. The entire picture cleared up 48 hours after interruption of therapy. He refused the "new medicine" thereafter. The third case expired suddenly at home and is presented in detail below. The only significant aberration observed in the electrocardiogram obtained six hours before his demise was a Q-T interval measuring 0.60 seconds.

In this connection it should be pointed out that the patient in case number 13 who had a Q-T of 0.58 each time sinus rhythm was established could not preserve the normal mechanics successfully, the auricular arrhythmia quickly returning when the quinidine dosage was slightly reduced.

While it would be unwarranted to draw any definite conclusions from such a small series of cases, it is difficult to overlook the noticeable correlation between the prolonged Q-T interval and the possible presence of myocardial toxicity which in one instance developed after a relatively small quinidine intake.

QUINIDINE TOXICITY

It would be sheer folly to assume that quinidine is an absolutely safe drug. Toxic reactions of varying severity occurred in a large number of the patients treated.

McMillan and Welfare[16] reported an incidence

as high as 64 per cent in their series of cases. Most authors encountered lower percentages. We had our share of them.

The toxic effects of quinidine can be divided into:

I. Undesirable Symptoms and Signs:

A. Gastrointestinal disturbances
1. anorexia
2. nausea and vomiting
3. diarrhea

B. Central nervous system manifestations
1. dizziness
2. headaches
3. numbness
4. tinnitus
5. diplopia
6. deafness

C. Others
1. dermatitis
2. fever
3. malaise.

In our own series the outstanding offenders were anorexia and diarrhea. Fortunately the more serious ones like severe vomiting, diplopia, and deafness occur only rarely. We did not observe them among our patients and most investigators do not mention them. In general side reactions are not intolerable and the vast majority can be readily controlled with kaopectate,® paregoric, codeine, antihistaminics and aspirin.

It may be of some significance that several of these uncomfortable manifestations occurred in cases 5 and 6 while on ambulant therapy but were not evident after the patients were hospitalized and remained in bed.

II. Pronounced Hypotensive Reactions:

These call for immediate interruption of treatment. They are seldomly noticed being usually encountered when the drug is administered intravenously. None were observed in our group.

III. Idiosyncrasy or Hypersensitivity to the Drug:

Circulatory collapse and respiratory difficulties after the initial dose of quinidine are of extremely rare occurrence. This was not noticed in our series.

IV. Electrocardiographic Abnormalities:

A. *Auricular Flutter.* Most cardiologists nowadays regard this arrhythmia as a transition mechanism between auricular fibrillation and sinus rhythm and advocate continuation of therapy.

B. *Ventricular Premature Beats*: These should be interpreted as a danger signal and should lead to intensive evaluation of the patient. If they increase in frequency or occur in long runs or an actual ventricular tachycardia becomes established quinidine should be immediately discontinued. The danger should cease promptly since quinidine is rapidly metabolized, and very little can be recovered from the blood after 24 hours. Therapy may be attempted after an interval of 2 to 3 days. Commonly the arrhythmia may not recur during the second trial.

C. *Widening of QRS*: Most authors consider an increase in the QRS interval of 25 per cent or more as an indication for immediate cessation of treatment. The drug can be re-started later and some authors report conversion at lower dosage levels on subsequent attempts without any evidence of toxicity.

D. *Excessive prolongation of the Q-T Interval*: Even though prolongation of the Q-T interval is a normal event during quinidine therapy and in fact is a reliable criterion of quinidine effect, an excessively prolonged interval should be viewed with suspicion and the patient more carefully scrutinized for other signs of toxicity which if present makes termination of therapy mandatory.

E. *Auriculoventricular dissociation*: The appearance of this rhythm is an urgent indication for prompt discontinuation of the drug. We encountered this abnormality once in our group. The case was already discussed.

F. *Nodal Tachycardia*: This mechanism was evident twice in our study. Reduction of the dose of quinidine usually suffices to restore the sinoauricular node as the pacemaker. Nodal rhythm of one sort or another was noticed in all of our successful conversions.

V. Sudden Death

DEATHS

Three of the fourteen patients under observation have died up to the present time. One of them (Case 3) as stated before entered the hospital with a cerebrovascular accident with a right-sided hemiplegia, severe hypertension and advanced kidney disease with frank uremia. She was kept on quinidine despite the imminence of her exitus because of our interest in determining whether normal cardiac activity could be restored in the presence of an overwhelming renal insufficiency.

Case 4 constituted our second fatality. He expired 30 days after normal rhythm was reestablished and while taking 0.2 gram of quinidine three times daily. His electrocardiogram was discussed earlier. Bilateral lobar pneumonia and advanced nephrosclerosis were the salient postmortem findings.

A brief summary of the third case follows: The patient, a 56 year old white male, weighing 212 pounds and measuring 5 feet 10 inches in height, was admitted to the hospital March 10, 1952, in marked cardiac failure with a blood pressure of 230/140. Good compensation was promptly secured with the usual therapeutic measures. Subsequent fluoroscopic and radiographic

study revealed the heart to be greatly enlarged in all diameters, especially in the region of the left ventricle. The transverse diameter of the heart measured 20.0 centimeters. (The predicted transverse diameter according to Ungerleider and Clark formula was 14.8 centimeters.) His vital capacity was 37 per cent. Venous pressure 160 millimeters H_2O. Arm to lung time 8 seconds. Arm to tongue time 27 seconds. Quinidine therapy was instituted four days after admission and the dose was augmented every three to four days until he was receiving 0.6 gram at four hour intervals on March 29, 1952, the day of death.

Outside of mild episodes of nausea, no evidence of serious drug intolerance was noted. Numerous electrocardiograms failed to disclose any changes of consequence except for a prolongation of the Q-T interval. He left the hospital against our advice stating he was feeling fine and saw no reason for further treatment. He expired suddenly at home four hours after his departure from the hospital and six hours after his last dose of quinidine. An electrocardiogram recorded six hours before his demise showed auricular fibrillation with a ventricular rate of 70, QRS 0.11 seconds and Q-T 0.60. The prolonged Q-T interval was, perhaps significantly, the only conspicious abnormality noted in the last tracing which was not present in his first cardiogram.

It is obvious the first two deaths could hardly be attributed to the action of quinidine. In the absence of postmortem evidence the third case has to be designated a quinidine casualty even though the patient had a severely damaged heart with a probable aneurysm of the left ventricle and severe hypertensive vascular disease with a previous coronary occlusion.

CONTRAINDICATIONS

The contraindications to the use of quinidine in auricular fibrillation form the nucleus of a highly controversial issue. Widely divergent opinions have been expressed in this connection by various investigators. These vary from Gold's[22] "Treatment of Chronic Auricular Fibrillation with quinidine has been largely abandoned" to Yount, Rosenblum and McMillan's[18] more recent statement, "There does not exist convincing proof that the presence of any factor other than a history of severe reaction to the drug should prevent its use." Friedberg[23] prefers to avoid its administration in patients with significant heart disease with cardiac enlargement and decompensation and in those whose arrhythmia is of long duration and cites a slow ventricular rate due to partial or complete heart block as definite contraindications. Levine[24] mentions organic heart disease and White[25] congestive failure, serious heart disease or history of embolism as conditions in whose presence the use of quinidine should be withheld.

An increasing number of authors have successfully attempted conversion in diversified types of patients with chronic auricular fibrillation and have stressed the significant beneficial results obtained even in patients with advanced myocardial degeneration and decompensation.

With respect to the problem of embolism Askey[26] expressed the sentiments of most students of the subject when he stated that embolism is apparently a greater hazard if auricular fibrillation is allowed to continue than if normal rhythm is re-established.

Goldman[27] used quinidine in nine patients with bundle branch block without ill effects or widening of QRS. He remarked however, that complete A-V block is an absolute contraindication to the use of quinidine.

In summary it may be said that quinidine is contraindicated in patients with sensitivity to the drug and in the presence of an auriculoventricular dissociation. It would seem that the drug should be used with caution in certain cases of congenital heart disease where the appearance of a normal rhythm may alter unfavorably the already established circulatory dynamics. The presence of an intraventricular conduction defect or a bundle branch block should not be a deterrent to the use of quinidine. However, these patients should be watched very closely and the drug increased slowly.

SUMMARY AND CONCLUSION

A report is submitted on our study of fourteen unselected patients with chronic auricular fibrillation treated with quinidine.

Successful conversion to a regular sinus rhythm was achieved in 10 cases (71 per cent) of which five have retained their normal mechanism.

The duration of the fibrillation, the age of the individual or the severity of the heart disease as determined by the size of the heart, the appearance of the electrocardiogram, vital capacity, venous pressure and circulation time studies and the incidence of cardiac failure appears to have no significant influence on the outcome of therapy with quinidine.

A detailed analysis of the various individual cases is presented with emphasis on the therapeutic problems encountered and their management and with notations on the final results.

It appears that intensive quinidine therapy in an ambulatory patient is a much too hazardous undertaking. Hospitalization should be a treatment prerequisite since it provides the only satisfactory way in which constant observation of the patient with frequent electrocardiographic evaluation can be effectively accomplished.

We like to reiterate that in the revival of the principle of restoration of sinus rhythm in the patients with chronic auricular fibrillation a new tool has been added to the physician's therapeutic armamentarium which promises to add many

years of useful comfortable life to the otherwise hopeless cardiac cripple. This will entail the use of quinidine, a drug which for many years was regarded as exceedingly dangerous, being usually administered as a last resort, often in terminal cases and frequently without the proper control. A drug which more recently has been proven to be relatively safe if its toxic effects are recognized and its method of administration is understood.

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KEEPING UP WITH MEDICINE

• CALVES which eat the hidden coat of paint on the barn prompted a farmer to ferret out a magnesium deficiency in his soil. Would that patients were as instinctive.

* * *

• VITAMIN C is a catalyst for protein synthesis and thus it follows that it is necessary to the retention of this reserve. Yet most rural people most of the winter have a diet deficient in vitamin C.

* * *

• WE should be more aware of the dangers inherent in the use of topical medicaments as the result of sensitization and of the value of bland therapy in the treatment of skin diseases.

* * *

• WE should be especially mindful of our old sensitizers—mercury, sulfur, and iodine—and of our new mercurials, the nitrofurazones, the sulfonamides, the antibiotics, the "caine" group of local anesthetics (benzocaine, nupercaine,® etc.), and even more recently the antihistamine salves, creams, and lotions.

* * *

• CROSS sensitizations are being reported between azo dyes in nylon stockings, paraphenylenediamine occuring in hair dye, and para-aminobenzoic acid in patients sensitive to sulfonamides.

* * *

• Do not forget either that your patient whose skin has broken out after the use of sulfonamide drugs may well be sensitized crosswise to procaine.

* * *

• FINALLY, in patients known to be sensitive to paraphenylenediamine the eating of foods containing azo dyes certified for use in foods, drugs, and cosmetics may aggravate or light up a dermatosis.

* * *

• MEDICAL men cannot advise the elderly patient about his retirement for he has had no training whatever in preparation for his own retirement. Worse than that he illy understands the mental training and preparation for the peace of an unoccupied mind, for medicine is an anxious pursuit and the concerns of the moment are too engrossing to leave time for the contemplation of the remote future.

* * *

• EDEMA as a toxic sign in the therapeutic use of butazolidin® usually subsides within five days after the drug is discontinued.

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• THE simple procedure of holding the breath is frequently successful in relieving a "night cramp" of the legs which waken one from sound sleep. It is also reported as working in angina pectoris.—J. F.

The Management of the Herniated Intervertebral Lumbar Disc

WILLIAM M. HEGARTY, M. D., and CHARLES W. ELKINS, M. D.

THE anatomy of the intervertebral disc was first described in 1555 by A. Vesalius. Countless workers have clarified the anatomy of this structure since. For a great number of years tumefactions extending into the ventral part of the spinal canal opposite the intervertebral disc were considered to represent true neoplasms and were called interchangeably extradural chondromas, ecchondroses, fibromas and fibrochondromas. These protrusions of the intervertebral disc were probably only recognized as such no more than 23 years ago by Alajouanine and Petit-Dutaillis.

Probably the most credit for the pathophysiology and treatment of the herniated disc as it is understood today is due to Mixter and Barr. Since their original publication in 1934 there have been many contributions to the literature upon this subject much of which was collected and summarized by Bradford and Spurling in their monograph in 1941.

That the treatment of this entity remains far from satisfactory is evidenced by the diversified opinion concerning methods, the reluctance with which many neurological and orthopedic surgeons undertake the management of these cases and the published reports of almost uniformly mediocre results.

Since the initiation of the surgical attack upon this lesion some 20 years ago, several thousand discs have been operated upon by surgeons of this country with varying but, collectively, none too encouraging results. Once the diagnosis of sciatic neuritis *per se* came to be looked upon as a clinical curiosity, the herniated disc was substituted as the etiological culprit for all backs that ached. In fact this diagnosis became so popular and the operative results so poor during World War II that the Medical Department of the United States Army found it necessary to enforce some limitations upon the wholesale practice of operating upon these patients by surgeon-personnel who were not especially trained in this work.

As our own series of operated lumbar herniated discs has developed the results are found to compare favorably with most other reported series; we do not consider them to be entirely satisfactory. Based upon the premise that were candidates more carefully selected for this procedure and the operation perhaps more conservatively designed results would be considerably improved, the following study is presented to emphasize the errors in case selection and the faults in management. Many of our opinions have been altered and our methods revised as a result of the experience with these cases.

We have been able to follow some 258 operated cases, and although this follow-up has not been entirely adequate we feel that it has been complete enough to enable us to resolve a certain number of conclusions. Some of these cases have been followed by letter only, others by personal interviews and examination and the majority by both. Regardless of whether or not these patients were actually seen for follow-up, the statistical results were compiled entirely from the patient's own evaluation of his result. These statements were unaltered even in those instances where the personal knowledge by our staff was available to the effect that the patient's estimate of a poor result was not substantiated by the amount of disability he sustained or the amount of work that he was able to accomplish.

These patients were all veterans, principally of World War II, and they were all treated in a Veteran's Administration Hospital. The element of disability compensation quite appreciably figured into their estimation of the operative result. Despite the fact that these patients were assured to the best of our ability that questions and questionnaires were for statistical purposes only, this factor could not be divorced from the study. In a number of cases in which the patient estimated his operative result as poor, he also

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The cases utilized in this study were from the Neurological Surgery Service of the Crile V. A. Hospital, Cleveland, Ohio.
Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. Th statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

admitted that he suffered no leg or back pain and was losing no time at work. One patient who estimated his result as zero per cent stated that he was no better at all except for the fact that he no longer had pain! The estimates are therefore quite conservative.

STATISTICAL ANALYSIS OF STUDY

We have been able to follow 58 per cent of our cases from two to four years, and 42 per cent from six months to two years. We have arbitrarily considered an estimated 90 to 100 per cent overall postoperative improvement as an excellent result, 70 to 90 per cent improvement as a good result, 40 to 70 per cent as fair, and 0 to 40 per cent improvement as a poor result. Our study reveals that only 42 per cent sustained a good or excellent result, 36 per cent fair and 22 per cent poor.

Sixty-four and five tenths per cent were found to have no residual radicular pain, with 15 per cent stating that they experienced occasional slight radiating pain, and 20.5 per cent still suffering from moderate to severe pain of radicular character. There was residual subjective numbness found in 51 per cent to a moderate or severe degree, with 13.5 per cent stating that this lack of sensation was occasional and slight, while 35.5 per cent of the subjects had no such changes. It should be mentioned that in the estimation of their final result, several patients regarded residual "numbness" as a disabling factor regardless of the fact that they no longer suffered pain.

Fifty-eight per cent of our patients still suffered moderate to severe backache. Twenty-two and five tenths per cent complained of only mild and occasional backache, and only 19 per cent no longer suffered back pain.

Forty-four per cent of these operated cases claimed to be losing still an appreciable amount of time from their work, 6 per cent stated that they lost an occasional day, and 50 per cent only were losing no time from their employment. Furthermore, a fair number had changed their type of work from a heavy manual type job to a more sedentary occupation at which they were losing no time. The 50 per cent, therefore, indicated as losing no time from their work, does not necessarily imply that one-half of our cases were restored to the employment that they were pursuing prior to operation. The patients were also questioned regarding postoperative weakness of the affected extremity, however, this question was so often misinterpreted that it served no practical statistical purpose.

From a detailed preoperative and operative analysis of a group of 183 cases pertinent objective and subjective factors are revealed which assist in a more accurate selection of cases for operative intervention. If the clinical picture is well defined and the historical evidence is entirely consistent, we believe operation should be undertaken without the aid of myelography, but if the picture is not entirely convincing myelography should be employed.

In this series 131 myelograms were performed preoperatively, 67 per cent of which were entirely accurate when correlated with the operative findings. Six per cent were accurate in so far as the demonstration of pathology was concerned but erred in the exact localization of the interspace and were not frankly misleading to the surgeon. Twenty-one per cent of the myelograms were inaccurate, 17 per cent were negative, failing to reveal a herniated disc later demonstrated at the operating table while only 4 per cent were falsely positive, revealing a definite defect which could not be confirmed at operation.

Discography was not utilized in this series of cases. We are opposed to the introduction of any radiopaque material into the subarachnoid space unnecessarily for myelography is not an entirely innocuous procedure. We have observed a few cases of chemical meningitis in which patients experienced no permanent damage and one case which was apparently infected during this procedure and succumbed to a fulminating meningitis. The practice of introducing a radiopaque substance to be followed immediately by operation is not recommended for the reason that a sterile meningismus with a mild temperature elevation associated with a relative pleocytosis is difficult to differentiate clinically from an early meningitis. Unless sufficient time is allowed to elapse following myelography to accomplish this differentiation one may unknowingly proceed with operation in the face of a gross infection.

PREREQUISITES TO DIAGNOSIS

We believe the following factors to be of primary importance in the diagnosis of the herniated lumbar disc:

1. The history of intermittency has been furnished in practically all of our operated cases except those few which have been admitted during or following their initial episode.
2. The history of radiating pain has been noted in 93 per cent of the cases, and 82 per cent of this group had radiating pain down the posterior aspect of the thigh and calf along the course of the sciatic nerve.
3. Cough and sneeze pain has been present in 87 per cent of our cases.
4. Bladder symptomatology has been negligible in our series. One case of acute paralysis was encountered.
5. Thirty-nine per cent of our patients furnished a definite history of an injury immediately preceding the onset of their symptomatology. Interestingly enough three cases dated the onset of their symptoms immediately following a spinal anesthesia.
6. A positive Straight-Leg-Raising Test was

demonstrated in 92 per cent of the cases. We have noted that a contralateral straight leg raising is almost pathognomonic of a frankly herniated nucleus.

7. Paravertebral muscle spasm has been elicited in 83 per cent of the cases.

8. Trunk motion has been almost invariably limited in all directions.

9. Reflex change has been found in 78 per cent of cases. The tendon Achilles reflex was absent or diminished in only 23 instances of L-4 disc herniations without involvement at L-5. In 26 instances the patellar tendon reflex was found to be diminished or absent. Of this 26, there were 12 associated with herniations at the L-5 interspace, 9 with L-4 herniations, and five were associated with negative explorations. An absent or diminished posterior tibial reflex is reputedly suggestive of an L-4 disc but this reflex has not been consistently recorded in our group.

10. Consistent sensory alteration, i. e., hypesthesia to pin-prick, was observed in 64 per cent of the cases in 84 per cent of which the change was noted to be along the lateral aspect of the leg.

11. Loss, diminution or reversal of the normal lordotic lumbar curve was observed in 88 per cent.

12. A definite list in standing and walking was noted in 85 per cent of cases.

13. A scoliosis was noted in 78 per cent and a kyphosis in only 4 per cent.

14. There has been a pre or paravertebral tenderness observed in 80 per cent of cases.

15. Weakness of dorsiflexion of the toes was found in 42 per cent.

16. Measurable atrophy was noted in 39 per cent.

17. The cerebrospinal fluid protein values were determined and reported in only 50 per cent of the cases operated. Of this 50 per cent, 24 per cent were in excess of 75 milligrams per hundred cubic centimeters, another 24 per cent were in excess of 50 milligrams per hundred ccs. and the remainder were less than 50 milligrams per hundred ccs.

Of this series of 183 cases whose operative findings were correlated with the preoperative signs and symptoms 11 per cent of the interspaces explored were thought to be normal. Eleven patients had completely negative findings. (Interestingly in the follow-up of these eleven patients, three stated that they had sustained good or excellent results and five claimed a fair result.)

Two or more interspaces were explored at operation in 32 per cent of patients. Forty-one per cent of the explorations revealed frank ruptures of all or a portion of the degenerated nucleus through the annular ligament. Sixty-three per cent occurred at the lumbosacral interspace (L-5) exerting pressure upon the first sacral nerve root, 34 per cent at L-4, 2 per cent at L-3, 1 per cent between the fifth lumbar and a transitional sixth lumbar or lumbarized first sacral vertebra, and there were no instances of an L-1 or L-2 disc in this series.

Fifty-two per cent of the herniations were found to have occurred on the left, 45 per cent on the right and 3 per cent in the midline. There were ten instances of recurrence and four combined operations with the Orthopedic Service for exploration, removal of one or more herniated discs and fusion of the spine. One death occurred in the series secondary to transfusion reaction.

COMMENT

With regard to the opinion that compression of the nerve endings in the annular ligament by a herniated disc may produce referred pain in the back, hip and thigh only without sciatic radiation, we feel that although such a concept seems physiologically reasonable, in the selection of candidates for operation the pain should be required to descend for the most part throughout the course of the sciatic innervation. This requirement is borne out statistically.

The Naffziger or Viets test has not been routinely employed by us and therefore statistics as to its reliability in our hands are not furnished. We have felt that the cough and sneeze phenomenon is physically synonymous with jugular compression.

Although bladder symptomatology in our group of cases has been almost non-existent, if this factor is present with a history of acute onset, such a symptom constitutes an indication for emergency operation of the herniated disc.

Our statistics are consistent with the premise that the longer the history of symptomatology and the greater the number of recurrent episodes, the poorer the result and the greater the residual disability may be anticipated. Eighteen per cent of our cases had had their symptoms for over five years, 45 per cent from two to five years, another 14 per cent from one to two years and 23 per cent only less than one year.

In approximately 20 per cent of the cases notation was made by either the examiner or the psychiatric consultant of a functional element and, statistically at least, their opinion was correct in the operative result obtained.

Of particular import we have observed, in the ruling-out of the malingerer in these cases is the relative increase in severity of the paravertebral muscle spasm as the patient assumes an erect posture having first been asked to bend at the waist. As heretofore noted, trunk motion is almost invariably limited in the presence of a herniated disc, and although forward bending is usually extremely difficult and painful, the return

to an upright position is even more so and is never accomplished with ease. The muscle spasm is proportionately increased when the patient is asked to return to a natural position.

The concept that sensory change about the inner aspect of the calf and foot denotes an L-4 disc and that change along the lateral aspect an L-5 herniation, was substantiated in 80 per cent of the cases.

Scoliosis and list should statistically parallel each other and this is essentially borne out as previously noted. It has been said that the list is almost invariably away from the side of the protrusion due to a reflex attempt to enlarge the side of the interspace on which the disc protrudes, but we have found this situation to be quite variable in our series. It must be remembered that as the patient opens the interspace on the affected side, he simultaneously places the affected nerve root on a stretch. However, the patient does always favor the affected extremity and assumes a posture of weight-bearing upon the opposite member.

With regard to the cerebrospinal fluid protein, the values noted previously would at least suggest, assuming that a value of 50 milligrams per hundred cubic centimeters represents the upper limits of normal, that almost one-half of the herniated discs demonstrate relative elevations in the cerebrospinal fluid protein values. This estimate strikes a happy medium among the varying opinions noted in other reported series. It is fairly well the concensus that an elevated protein is not an outstanding characteristic of a herniated disc, however, Bradford and Spurling state that, "The elevated total protein is the only alteration of the cerebrospinal fluid characteristic of herniated nucleus pulposus, but, since it occurs in only 70 to 80 per cent of cases, a normal protein does not exclude such a lesion."

The use of the term "rupture" in this series presupposes that a rent in the annular ligament is visualized at operation and the terms "protrusion" and "bulging" are substituted unless such an actual rupture is demonstrated.

DISCUSSION

It has been said that practically all herniated intervertebral discs are eventually relieved of their pain without operative intervention. This statement we hold for the most part to be true. What is unsaid by those who advocate a purely conservative regimen in the management of these cases is that many such patients over the course of years endure countless acute episodes, each painful and disabling, each contributing to further neurological deficit, and each costing the patient a period of unemployment until such time as the prolonged pressure of a herniated disc has permanently destroyed the nerve root. Then the patient is admittedly relieved of his pain. This constitutes an endurance contest between the patient and his nerve root for which the trophy is too often a crutch. One often hears of the countless number of patients with clinical pictures unequivocally diagnostic of herniated disc who experience a few severe "sciatic" attacks and then completely recover. We do not encounter a significant number of these in practice or in the literature.

The treatment either conservative or operative has not been consistently encouraging. However, we have statistically shown in a small series of cases those factors which are most likely to present in a diagnosis of herniated discs at the operating table. It is our opinion that if one adheres to the findings heretofore mentioned that candidates for surgical intervention in whom a good result may be reasonably anticipated can be accurately selected. If the prerequisites to diagnosis can be fulfilled we believe that operation can afford such a patient an excellent result, and that operation should therefore be advised practically without exception.

It is obvious in the group of cases previously presented that operative treatment was undertaken late in the course of the disability. Only 23 per cent had complained of their symptoms one year or less. Forty-two per cent already had motor weakness and 39 per cent had progressed to measurable atrophy. One cannot reasonably expect as good a result in any type of operative surgery if irreparable damage has occurred. We believe the disc problem represents no exception, and that operation should be advised early in the patient's disease.

An atrophied muscle is evidence that its nerve supply has been damaged and the removal of an element of compression upon the nerve root cannot be expected to produce regeneration of atrophied muscle fibers. One cannot expect such an event to follow the removal of a spinal cord tumor and it is no more to be expected in a herniated disc. In our opinion the deferment of surgical treatment in a patient in whom a definite diagnosis of disc can be made is a physiologic error. Our own results in frank ruptures of short duration support this impression.

OPERATIVE PROCEDURE

The type of operation to be employed deserves comment. The technique has not been standardized and has varied with different eras and different operators from the simplest exploration to complete laminectomy of the entire lumbar spine. We have come to believe that the lesion should be as accurately localized as possible preoperatively, and that the operative procedure should be limited to as simple an exploration as can be satisfactorily accomplished. If the disc cannot be accurately localized clinically then a myelogram is indicated and is preferable to indiscriminate exploration. Multiple interspaces were explored in 32 per cent of our

operations with only 14 instances of multiple disc being found.

We feel that the loose degenerated nucleus pulposis should be removed but we see little to be gained by curetting away the cartilaginous end-plates of the vertebral bodies. The rent in the annular ligament fibroses rapidly. Any small remaining portion of intervertebral-space contents will infrequently find its way out and beneath the nerve root. We feel that curettage and vigorous attempts to remove cartilage from the interspace is unnecessary and that such trauma predisposes to further degeneration of the cartilaginous contents and to osteophytic formation. Furthermore, such heroic debridement of an interspace has proved dangerous in the presence of a thin and flaccid anterior spinous ligament. We feel that the use of the coagulating current is practically never warranted in the epidural space and that bleeding can usually be satisfactorily controlled with light pressure and the use of gelfoam.® We do not routinely use oxycel® cotton.

In the instance of an inadvertent rent in the dural sheath during a dissection about a nerve root, the attempt should rarely if ever be made at closure for such an attempt is usually more traumatic than effective, and we have experienced no instances of spinal fluid leak following this operation. We feel that a small partial hemilaminectomy with exploration of one interspace should suffice in the vast majority of these cases.

POSTOPERATIVE MANAGEMENT

Practically all of the patients in the cases presented were ambulated early. They were allowed to stand to void on the day of operation and were allowed out of bed on the day following. The theory is possibly sound that a period of postoperative immobilization allows the rent in the annular ligament to heal closed. We have, however, felt that the advantages of early ambulation outweigh the disadvantages. We oppose the long-practiced period of "dangling." This practice in our opinion defeats one of the principal purposes of early ambulation, i. e. the prevention of vascular occlusive phenomena.

All operations in this series were performed under spinal anesthesia. In many instances spinal anesthesia was supplemented with intravenous sodium pentothal® in 0.5 per cent solution. There were no anesthetic complications.

These patients were usually discharged on the fifth to the seventh postoperative day. They were advised against any type of manual labor for a period of six weeks after operation, and no lifting or straining was recommended before three months. Braces were not routinely prescribed, but chair-back braces were recommended for those in whom instability of the lower spine was demonstrated at operation. Emphasis upon corrective exercises was not made routinely at the time these patients were discharged from the hospital but we feel that such instruction should be incorporated as a routine measure.

SUMMARY

A follow-up study of 258 cases of operated herniated intervertebral lumbar disc is reported.

A series of 183 cases has been analyzed to correlate the preoperative signs and symptomatology with the operative findings.

From the experience gained a suggestive regimen for the management of these cases is presented.

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The Nephrotic Syndrome

The nephrotic syndrome is a disease state characterized by edema, hypoproteinemia, lipemia, proteinuria, and perhaps evidences of a degenerative renal lesion in the urinary sediment. Its etiologic delineation is varied, and often cannot be determined. The syndrome may take place as a consequence of glomerular nephritis when this disease enters the degenerative stage, and it has been seen in association with amyloidosis.

It is thought to occur sometimes as a "hypersensitivity reaction" to a variety of stimuli, the terms lipoid nephrosis, pure proteinuria and prerenal proteinuria having been used to describe this condition, which occasionally may be cyclic. Rytand described patients in whom the nephrotic syndrome was associated with poison oak dermatitis. The author has observed patients in whom it seemed to be induced by the administration of gamma globulin to ameliorate rubeola, by multiple insect bites, by therapy with penicillin and by the use of sulfonamides.

While the nephrotic syndrome occurs most frequently in childhood, it may occur at any age. In some cases the disease may terminate fatally, but in a substantial number it may disappear and eventually heal completely. This difference in outcome is unexplained, but it does not appear to depend entirely upon the cause of the disease.—Edward C. Persike, M. D., San Francisco, *California Medicine*, 77:299, November, 1952.

Epipharyngeal Crypts

WILLIAM J. LOEB, M. D.

RECENT experience has brought to our attention a series of 100 patients whose otolaryngologic complaints have been caused by epipharyngeal disease of a particular type. The frequency with which this has been observed and the variety of associated and presenting symptoms would seem to justify a restatement of this subject, which has been well described in the recent literature.

Carmody[1] referred to the epipharynx as "The Almost Unknown in Otolaryngology." This paper brought to attention the fact that the epipharynx was not properly studied in otolaryngologic examinations. In spite of the repetition of this fact by many writers and teachers for many years it is unfortunately true today that insufficient attention is still paid to this region. Hollender[2] has devoted much time and effort to elucidating epipharyngeal disease. His fine review of the literature gives the background to our present concept of cysts, crypts and inflammatory lesions.

Dorrance[3] presented a study of the epipharyngeal bursa. Theobald[4] likewise studied the subject, presenting a picture of the symptoms of epipharyngeal disease, including tumors. These and many others including Kully,[5] Lion,[6] Eagle,[7] and Hollender[8] have made it abundantly clear that the epipharynx is frequently the location of lesions causing distressing symptoms. It is our purpose to consider in greater detail one type only; the mid-line crypt or recess.

The Author

● Dr. Loeb, Cleveland, Ohio, is a member of the staff at Mt. Sinai Hospital.

MID-LINE CRYPTS

The patients in this series presented themselves with complaints of lump in the throat, sore throat, headache, post-nasal drip and crusts, blood in the throat, and cough. The differential diagnoses required in evaluating these symptoms encompass many diseases.

The otolaryngologic approach to diagnosis requires inspection of the entire upper airway. All 100 patients so examined revealed no evidence of tonsillitis, sinusitis, or the more frequent causes of pain and discomfort about the throat and head. Further inspection was then turned to the epipharynx. Anterior rhinoscopy after nasal shrinkage then revealed in each patient the presence of a rounded smooth-bordered clear-cut hole in the mid-line of the epipharynx, just above the level of the palate. Some were elliptical, some circular.

The openings varied in diameter from 1 to about 5 mm. In most there was an undermined crypt distal to the opening, which on probing was found to be considerably larger in diameter than the channel communicating with the pharynx. Many of these crypts on first inspection were covered with, and the openings plugged by large tenacious crusts which were removed with great difficulty.

CHARACTERISTIC SYMPTOMS

Referring to the accompanying table I, the distribution of symptoms is shown in column 2 through 8. The most common history describes sore throat and post-nasal drip with mucoid plugs. Patients tell about this in a way which

TABLE I
RECORD OF PATIENTS

1	2	3	4	5	6	7	8	9	10	11
Patient	Lump in Throat	Sore Throat	Headache	Choking	Post-nasal Drip. Crusts	Blood in throat	Cough	Relieved by Rx. Number of Rx.	Symptoms provoked & relieved by Rx.	Remarks
1	X							X 1	X	
2		X	X	X	X			no	X	
3		X		X				X 2	X	
4		X			X			X 8	X	
5		X			X			X 8	X	
6		X			X		X	X 3	X	
7					X			X 2		
8					X			X 1		
9	X	X						X 1	X	
10		X			X			X 9	X	
11					X			X 4		
12		X	X					no	X	
13		X			X			X 1	X	
14					X		X	X 1	X	
15	X	X							X	No Followup
16		X			X			X 2	X	
17		X							X	No Followup
18	X	X						X 2	X	
19	X				X			X 2	X	
20		X		X	X				X	No Followup
21	X	X			X			X 5	X	
22					X			X 4		
23		X			X			X 6	X	
24	X							X 4	X	
25		X						X 1	X	
26		X						X 10	X	1 recurrence yr. later; asymptomatic 5 yrs. after 2nd course 3 treatments
27					X					No followup
28							X	X 1	X	
29					X			X 1		
30	X			X				X 1	X	

Submitted June 30, 1952.

TABLE I (Continued)—Record of Patients

1	2	3	4	5	6	7	8	9	10	11
Patient	Lump in Throat	Sore Throat	Headache	Choking	Post-nasal Drip. Crusts	Blood in throat	Cough	Relieved by Rx. Number of Rx.	Symptoms provoked & relieved by Rx.	Remarks
31		X						X 1	X	
32	X		X					X 2	X	
33					X			X 4		
34		X						X 1	X	
35					X					No followup
36		X			X			X 2	X	
37		X			X	X		X 2	X	
38					X			X 2		
39		X						X 3	X	
40	X				X			X 2	X	
41		X						X 2	X	
42	X							X 1	X	
43					X			X 5		Recurrence 1 yr. Later
44		X			X			X 2	X	
45	X				X			X 4	X	
46	X	X						X 11	X	
47	X							X 3	X	
48	X	X							X	No followup
49		X							X	No followup
50	X	X			X	X		X 9	X	1 recurrence relieved by further Rx.
51	X				X			X 8		
52		X						X 1	X	1 recurrence relieved by further Rx.
53					X		X	X 3		
54		X						X 1	X	
55		X							X	No followup
56		X						X 2	X	
57	X	X			X			X 7	X	
58			X					X 2	X	Atypical neuralgia
59	X	X						X 5	X	
60					X		X	X 7	X	
61					X			X 7		
62		X						X 4	X	
63		X			X			X 7	X	
64					X		X	X 3		
65	X	X						X 4	X	
66					X	X		no 12		
67		X			X			X 1	X	
68		X			X			X 1	X	
69	X							? 5	X	Severe neurosis
70		X						X 1	X	
71	X	X						X 5	X	
72		X						X 1	X	
73			X						X	Atypical neuralgia
74	X	X						? 8	X	
75		X						X 2	X	
76					X					Crusts seen in crypt No followup
77	X	X							X	No followup
78		X							X	No followup
79			X					X 4	X	
80			X					X 3	X	
81					X					Crusts seen in crypt No followup
82		X			X			X 10	X	
83			X		X			X 1	X	Atypical neuralgia
84	X				X			X 4	X	
85		X						X 2	X	
86		X						X 4	X	
87	X	X						X 7	X	
88	X	X						X 1	X	
89		X				X			X	No followup
90	X							X 4	X	
91	X			X	X				X	No followup
92			X		X			X 1	X	
93			X		X		X	X 2	X	
94		X						X 2	X	
95			X					X 1	X	
96		X			X			X 2	X	
97	X	X						X 2	X	
98	X	X						X 4	X	
99		X			X			X 3	X	
100		X						X 1	X	
Ttl.	30	59	11	5	47	4	7			

is almost pathognomonic of the epipharyngeal crypt. They mention the feeling of something in the throat, frequently noted on arising in the morning. After much clearing of the throat, coughing and hawking, the plug of mucus is expelled through the mouth. Many patients had been treated for "sinus" or "allergy" because of this complaint.

The most frequent symptom was sore throat. No history of acute tonsillitis was obtained; no febrile sore throats. These are intermittent mild to moderately severe sore throats appearing for a few hours and then subsiding. The symptoms occur over a period of months to years. Tonsillectomy had been performed in most of these patients, either remotely or because of the sore throat, without relief.

In evaluating the relations between the presence of an epipharyngeal crypt and its etiologic factor in causing symptoms, it was felt that such a causal relationship could not be proven unless the symptoms of which the patient complained were provoked by probing the crypt, and then completely relieved by anesthesia of the area. Column 10 shows this to be the case in patients marked with an "X." Those patients who complained of drip and crusts could not fit this pattern, since the crusts could not be provoked by probing. Such crusts were visualized on examination however.

SUBJECTIVE REACTIONS

Patients with sore throat usually pointed to either side of the upper neck as the sore spot. On probing the cyst, the patients complained of pain in this neck area. The patients did not recognize that the probe was in the epipharynx, but felt it in the neck. While it is always difficult to evaluate subjective reactions the correlation between the site of pain or discomfort described in the history, and that described during probing of the crypt matched so closely with no prompting on the part of the examiner that it cannot be ignored. With relief of symptoms following anesthesia of the crypt, it becomes reasonably certain that the crypt is the etiologic agent.

More dramatic were cases 58, 73, 83, and 95. These patients complained of severe generalized headache recurring at intervals of several days and lasting one to twelve hours. The pains were those frequently described as atypical facial neuralgia. During examination none of these patients had symptoms. Typical headaches were produced by probing the crypts and were stopped promptly by anesthesia of the crypts. Complete lasting relief was provided by local treatment of the lesions.

Patient No. 28 was also unusual. She complained of non-productive cough for several months. Complete chest study including x-rays

and sputum examinations failed to reveal a cause for the cough. During examination probing the crypt started the cough. After one treatment the cough disappeared and has not returned during an 18 month follow-up period.

TREATMENT

Treatment of these lesions was undertaken with the thought of destroying the secreting cells to prevent formation of plugs, and to saucerize the crypts so that they did not retain secretions. It was felt that silver nitrate would accomplish this with minimal discomfort to the patient and with minimal interference with surrounding tissues. Accordingly, a solution of 10 per cent strength was applied directly to the crypt after topical anesthesia. Patients complained of exacerbation of symptoms for about two hours after therapy, and then improvement. The improvement lasted for varying periods, sometimes a day, and in some instances gave permanent relief of all symptoms.

After treatment was begun there was no predictable length of time before lasting improvement was noted. Some patients responded gradually, reporting progressively increasing freedom from symptoms; first for a few days, then a week, then for two weeks before recurring complaints brought them back for more treatment. Some patients went for four to six treatments with very little improvement and then rapidly lost all complaints.

The frequency of treatment was based on the subjective report of the patient. At first once a week, then as symptoms cleared every two weeks, therapy was gradually given at increasing intervals. When the patient experienced two symptom free weeks treatment could usually be discontinued with the prospect that the remission was permanent. As may be seen in column 10 of the chart long periods of treatment were rarely needed.

It is unfortunate that the criterion of therapy must be the unreliable subjective response. Objective changes in the crypts were noted but often showed no positive correlation with subjective improvement. As previously noted it was intended to treat until the lesion was obliterated or saucerized. In almost all patients lasting relief was obtained before this was accomplished.

No valid reason to continue further treatment has been shown. Most lesions showed enlargement of the communicating channel and a cessation of mucoid discharge and plug formation. Several were completely obliterated. Column 10 shows that ten patients did not report for follow-up after the first treatment. Patient No. 2 was not given satisfactory relief of his complaints. The remaining 89 all were completely relieved.

The term cure has been avoided because only prolonged follow-up, for at least a five year period, is considered a prerequisite to a true cure of this disease.

SUMMARY

The epipharyngeal crypt has been reviewed and shown to be the cause for many complaints seen frequently by the otolaryngologist. Recognition of this lesion and proper treatment will provide relief of symptoms and may avoid ineffective tonsillectomy and nasal therapy. It is believed that the incidence of epipharyngeal crypt is much higher than has been generally appreciated.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Tourniquet — The French military surgeon, Morel, in 1674 during the siege of Besancon devised an arrangement for applying pressure over a large artery to stop the flow of blood. The word tourniquet was originally applied to the stick or handle that was turned in order to tighten the bandage, and later the term was extended to include the entire device. The term was adopted into English in 1695 from the French and literally means an instrument for turning. The word tourniquet comes from the French word "tourner," to turn, and this in turn is derived from the Latin word "torqueo" meaning, I twist.

Minim—A term used in medicine to denote the smallest liquid measure or dosage of a medicine, which is a drop. Due to the uncertainty of the size of a drop, the London College of Physicians in 1860 defined a minim as the one-sixtieth part of a fluid-dram. The term minim is derived from the Latin word "minumus" meaning least or smallest. This in turn is probably related to the Greek word "minys" or small.

Troches—This term is now applied in pharmacy to disc-like masses of medicinal substances which are to be dissolved slowly in the mouth. The term was originally used by the Ancient Greco-Roman physicians for any disc-like or wheel-shaped mass of medicine. It is a simple descriptive term which alludes to the shape of the substance and is derived from the Greek word "trochos" or wheel.

—Harry Wain, M. D., Mansfield, Ohio.

Lymphogranuloma Venereum Rectal Stricture Cured with Aureomycin

LUTHER O. BAUMGARDNER, M. D.

AS recent as thirty years ago lymphogranuloma venereum was little if at all understood. The disease has existed for ages but the cause was not known. The manifestations of this disease were explained on grounds now known to be no longer tenable. The inguinal adenopathy was ascribed to gonorrhea, or syphilis, or chancroid infection. Wholesale removal of inguinal lymph nodes was the prevailing treatment. Rectal strictures were thought to be caused by syphilis or tuberculosis.

The Author

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A VIRUS DISEASE

Now we know that lymphogranuloma venereum is caused by a virus and that there are different strains of the virus.

The initial lesion in the male occurs on the penis. In the female it occurs on the vulva, cervix, or vaginal wall. The initial lesion is of short duration and may receive slight, or no attention from the patient. Rectal strictures due to this infection occur chiefly in the female. This is due to the virus entering the rectum and perirectal tissues by way of the extensive lymph channels and nodes in this region. In the male the infection involves the inguinal nodes chiefly, but rectal involvement in the male may occur as a result of perverted sexual habits.

Lymphogranuloma venereum infection of the rectum causes inflammation and then ulceration of the bowel. Perirectal edema, induration, and then scar tissue formation occur. Stricture formation in the rectum is a late result. The disease process may involve rectum, sigmoid, or whole colon. Often there are skip areas of infection. The strictures may be multiple, tubular, annular, soft, or hard. Fistulas, parametritis, inguinal adenitis, and elephantiasis are frequent accompaniments.

SYMPTOMS

Passage of blood and pus, diarrhea and pain are some of the symptoms. In late cases with narrow strictures there are narrow stools, constipation, and in some cases, obstruction.

Rectal examination will reveal strictures and associated fistulas can be seen. Proctoscopic examination is useful in some cases but must be done carefully to avoid injury to the diseased bowel. Barium enema is necessary to diagnose lesions in the sigmoid, and ascending colon. The Frei test is positive and should be done in all these cases.

Submitted July 24, 1952.

SPECIFIC THERAPY

Treatment of these patients was very unsatisfactory until aureomycin and terramycin became available. These antibiotics have a specific effect on the virus and in some cases are curative. Penicillin and the sulfonamides help to clear up the secondary infection which is always present but do not affect the virus infection.

SURGICAL TREATMENT

Various operative procedures have been devised to deal with the late results of rectal strictures. Colostomy is the most commonly used operation. This puts the bowel at rest and may be used as permanent procedure or as a preliminary procedure to more definitive surgery. Breidenbach and Slattery do a posterior resection of the strictured bowel above the anus and anastomose the divided bowel thus preserving the sphincter. Wright and others have advocated a "pull through" procedure after excising the strictured bowel and mobilizing the healthy bowel thus preserving sphincter function.

Abdomino-perineal resection is done in some cases.

All of this surgery while justified in malignant disease may cause one to pause and reflect when contemplated in benign disease. A recent experience with a rectal stricture treated with aureomycin has been of such interest as to prompt me to report the case.

REPORT OF CASE

Mrs. ------, colored housewife, aged 43, was first seen at her home Dec. 6, 1949. She was confined to bed and complaining of nervousness, diarrhea, and abdominal cramps. Rectal and vaginal examination revealed a brawny induration of the rectum, vagina, and pelvis. The uterus was moderately enlarged, hard and immobile. There was a stricture of the rectum 4 cm. from the anus which would not admit the index finger.

She also complained of pains in her legs and

arms and loss of weight. A diagnosis of lymphogranuloma venereum with rectal stricture was made. A Frei test was positive. Patient stated that she had been told that she had a rectal stricture four years prior to my examination.

On December 13, 1949, she was started on aureomycin 250 mg. every 6 hours. On December 17 she complained that she could not take the aureomycin because it nauseated her. She was advised to reduce the dose to two capsules daily and to take the medicine with chocolate milk. On December 21 she felt better, appetite was good, slept well, stools were not watery or bloody and there was no intestinal distress. However, she still complained that the aureomycin made her sick. On January 3, 1950, patient said she felt better and was able to take two aureomycin capsules of 250 mg. daily. On January 10th patient felt good, temperature 97°F., pulse 82, blood pressure 130-90.

On January 24, rectal and vaginal examination showed that the uterus was smaller and movable. The rectal wall was softer and more pliable. The stricture was softer but still would not admit the index finger. No pain or tenderness were present on examination.

On January 31st patient passed some blood per rectum. On February 7, 1950, there was some rectal bleeding.

On February 14th blood for Kline test was taken. Kline standard was doubtful. Kahn standard was negative. The rectal stricture admitted the tip of the index finger and the rectal wall was not indurated. The uterus was now freely movable, hard, enlarged, and in an anterior position. Pelvic and vaginal induration had subsided.

On February 28, 1950, patient was examined at the office. She was asymptomatic. Weight 127 pounds. Rectal wall was not indurated. Stricture admitted index finger. Uterus was slightly enlarged; adnexae not palpable. Aureomycin was discontinued.

Follow-Up: On May 14, 1951, patient was examined at the office. Weight 162 pounds, blood pressure 150-104, pulse 72. Ano-rectal examination revealed a normal rectum with no induration or stricture. August 11, 1951, patient was seen again and examined. Blood pressure 154-104, weight 154 pounds. Rectal wall was of normal consistency and there was no evidence of rectal stricture.

COMMENT

This patient presented the common picture seen in rectal strictures due to lymphogranuloma venereum. Operative measures certainly would have been indicated in the absence of specific therapy. In 1949 aureomycin was new and not much experience had been accumulated concerning the range of its effectiveness in lymphogranuloma venereum rectal strictures. Wright and his associates had reported some encouraging results in this disease at Harlem Hospital in New York.

Aureomycin in 1949 cost the patient about one dollar for a 250 mg. capsule. It was explained to the patient that she might be helped by the drug and in that event the expense could well be discounted. She took about 150 capsules of 250 mg. over a period of about two months. The aureomycin nauseated her so that she could take only two or three capsules a day. The results in this case show that the effective dosage of aureomycin may not be as large as is sometimes advised.

After two months of treatment the patient had gained at least 10 pounds in weight and was symptom free. The rectal stricture was still present but the rectal induration was absent and the caliber of the stricture was larger. This patient's medication was discontinued and she was told to come in for an examination in three months. She did not come in until 15 months later, at which time she had gained 35 pounds more in weight and rectal examination showed a normal rectum with no evidence of stricture.

Of course, when the bowel has been reduced to a fibrous cord no treatment can restore it to normal. However, the results in this case convince me that one cannot tell how much resolution is possible in these cases from examination alone.

If more of these seemingly hopeless cases were treated thoroughly with aureomycin many of these patients will be spared major operations.

SUMMARY AND CONCLUSIONS

1. A brief discussion of the salient features of lymphogranuloma venereum is given.

2. A case of lymphogranuloma venereum with rectal stricture cured by treatment with aureomycin is reported.

3. Many of these patients will be cured if treated thoroughly with aureomycin, or chloromycetin.®

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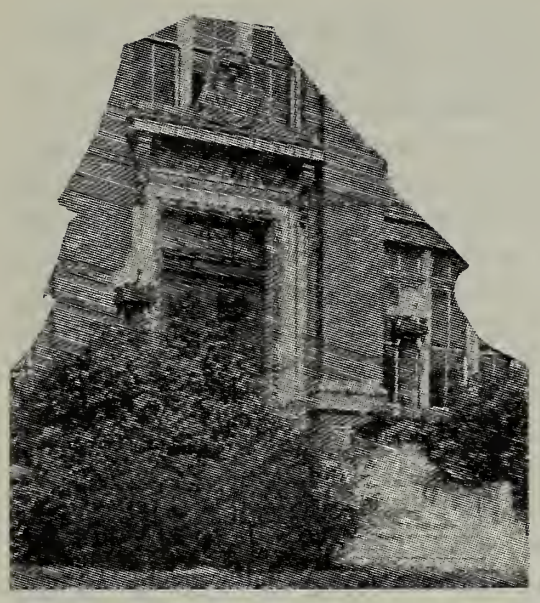
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New Drugs in the Treatment Of Hypertension

In general, we have been encouraged by the use of these drugs, particularly hexamethonium bromide, in the treatment of selected cases of essential hypertension. Subcutaneous administration of hexamethonium bromide produces a lowering of blood pressure in most cases and in many it produces a marked orthostatic hypotension with all the unpleasant secondary effects. These effects usually persist for three or four hours and usually become less noticeable as the injections are continued, even though the dosage is increased. We have observed the development of tolerance to the combined program in several patients within the first few weeks of treatment. —Edgar A. Hines, Jr., M. D., Rochester, Minn., *Minnesota Medicine*, 35:1021, November, 1952.



A Case Record

From The Cincinnati General Hospital

Edited Under the Auspices of the Ohio Society of Pathologists

Robert Ritterhoff, M. D., President

Presented by Helen I. Glueck, M. D., and Pearl M. Zeek, M. D. Edited by E. A. Gall, M. D.

PRESENTATION OF CASE

A 59 YEAR OLD white male was admitted to the hospital by stretcher in a drowsy state and died 14 hours later.

The patient had been a severe diabetic for 16 years. His glycosuria had been extremely difficult to control, although significant acidosis had never occurred. Since the onset of the diabetes he had been hospitalized on numerous occasions for attacks of generalized urticaria which initially were thought to be due to insulin sensitivity but subsequently were attributed to bacterial allergy because of a close correlation with upper respiratory infections.

Sometimes these episodes of urticaria were accompanied by marked hypotension and a shock-like state which responded readily to intravenous infusion of isotonic saline solution. Physical examinations during the hospitalizations revealed the following consistent findings: blood pressures 90/50 to 110/70; an enlarged, firm, smooth, non-tender liver extending two fingerbreadths below the right costal margin; and a peculiar discoloration of the skin variously described as "sun-tan," "sallow with a grayish cast," and "faint tanning or bronzing." A biopsy of the skin showed the presence of hemosiderin said by a consultant pathologist to be within the limits of normal variation.

For one month prior to his final admission the patient had had a cough, worse in the morning, productive of a moderate amount of white frothy sputum. There had been no chills, fever, chest pain or hemoptysis. The night before admission he suddenly became nauseated and vomited several times. Abdominal distention and periumbilical colic followed. He became progressively drowsy and was brought to the hospital.

Physical Examination: The patient was acutely ill, drowsy and restless, but had no pain. The temperature was 98.4°. The skin was thin, somewhat dry and had a cafe-au-lait color. The eyes, ears, mouth and pharynx were not abnormal. A questionable nodule was palpated in the upper left lobe of the thyroid. Respirations (32 per minute) were relatively shallow but there was apparently no air hunger. Slight dullness and numerous moist inspiratory rales were heard over the left lower lobe. The pulse rate was 116 per minute and the blood pressure 75/45. The area of cardiac dullness was not enlarged, the cardiac sounds were of fair quality, and no murmurs were heard. Pulsation of the dorsalis pedis arteries was absent and there was no venous distention. The abdomen was slightly distended and tender generally. The inferior border of the liver was not palpable but was percussed 3½ fingerbreadths below the right costal margin. Rectal examination was not remarkable. The abdominal, patellar and Achilles reflexes were absent but the tendon reflexes of the upper extremities were intact. Babinski's sign was not elicited.

Laboratory Findings: The erythrocytes numbered 4,320,000 with 13 Gm. of hemoglobin; the leukocyte count was 8,450 with 73 per cent segmented neutrophils. Blood chemistry studies revealed a CO_2 combining power of 42 vol., chlorides of 627 mg., and glucose of 110 mg. per hundred cubic centimeters. A guaiac test on the stool was negative.

Hospital Course: About one and one-half hours after admission abdominal distention became marked as a result of dilatation of both the intestines and the urinary bladder. The patient was unable to void voluntarily and catheterization was not believed indicated until about five hours after admission, when the procedure was

performed. The urine obtained contained 1 plus sugar, a trace of albumin, no acetone, and no abnormal sediment. X-rays taken six hours after admission revealed a small infiltrate at the extreme base of the left lung, high diaphragms, and moderate gaseous distention of the colon and possibly of one or two loops of small bowel. At this time the leukocytes numbered 5,900, the CO_2 combining power was 28 vol., the blood sugar 250 mg., and the serum amylase 80 units. Electrocardiograms taken during the eighth hour were normal in all leads.

The blood pressure began to fall slowly until it became imperceptible. Drowsiness deepened into coma and progressive cyanosis appeared. Despite intensive therapy the patient showed no improvement and expired 13½ hours after admission.

CLINICAL DISCUSSION

Dr. Helen I. Glueck: After reading the protocol the question one asks one's self immediately is, "What produced coma and death in this patient?" I shall attack the problem from this point of view, discussing the various causes of coma, trying to include or exclude each as the primary cause of death.

Let us first discuss the most obvious diagnosis in this patient, that is, diabetic acidosis and coma. Certain atypical findings suggest that diabetic acidosis was not the cause of death. On admission the patient was drowsy but apparently responded. Unconsciousness on admission is a serious prognostic sign in diabetic acidosis, yet in this case the patient's state of consciousness deteriorated after adequate treatment. This is most unusual in a well treated case of diabetic acidosis.

Shock, falling blood pressure, abdominal pain and distention may be considered signs of impending coma, but the hypotension usually associated with diabetic acidosis responds well to therapy as the patient improves. Abdominal pain is so frequent and so confusing a symptom in diabetic acidosis that diabetic acidosis must always be clinically differentiated from the "acute abdomen." Moreover, "the acute abdomen" may precipitate an episode of diabetic acidosis and coma.

One must therefore consider the diagnosis of acute pancreatitis in this case. Periumbilical pain, abdominal distention, shock and oliguria, all may be associated with acute pancreatitis. A bit of evidence which helps exclude the diagnosis was the normal serum amylase. The absence of leukocytosis also helps to exclude this entity.

A perforated viscus, as for example a perforating peptic ulcer, may produce the symptoms described in this protocol, yet the absence of abdominal rigidity, failure to find air under the diaphragm, or blood in the stool, and finally a normal white blood count speak against this diagnosis. I believe therefore that a surgical complication did not exist in this patient.

"CHEMICAL RECOVERY"

We have all seen diabetics in severe acidosis with a low CO_2 combining power, high levels of blood sugar, the urine loaded with acetone and sugar, who recover "chemically" but expire nevertheless. These are the patients who arrive at the hospital in deep coma with all the chemical findings of acidosis, respond well to therapy with a rising CO_2 combining power, but whose state of consciousness remains unaltered in spite of adequate treatment. It is impossible to fit this patient into this category. Unconsciousness on admission with a CO_2 combining power of 42 vol. is extremely rare; in fact Joslin and his associates[1] set a level of 20 vol. as the "coma level" in their patients. Moreover, the blood sugar of 110 mg. on admission was certainly not indicative of diabetic acidosis. Rather would I implicate some complicating factor which later increased the tendency to coma, since the CO_2 later fell to lower levels (28 vol.). Low blood chlorides are common in diabetic acidosis; and leukocytosis, absent here, is a usual laboratory finding.

If, therefore, we feel that the patient did not expire from diabetic acidosis, we must search further for the cause of death. Myocardial infarction could well produce abdominal pain and distention, a shocklike state, falling blood pressure and even coma. We can perhaps assume that some forward failure of the heart was present since pulsations were absent in the dorsalis pedis arteries. Moreover, patients who are diabetic for many years are good candidates for coronary thrombosis. One cannot definitely exclude this diagnosis from the evidence presented. The normal electrocardiogram is negatively helpful, yet typical changes in the tracings are often absent eight hours after the infarct occurs. Fever and leukocytosis are commonly associated with myocardial infarction but are often absent early, especially when the infarct is accompanied by shock. However, in the absence of all these signs, and the failure to give a clinical history of precordial pain and its typical radiation, I do not believe that the patient died from a myocardial infarct.

ALLERGY?

Did this patient die from an allergic reaction? Acute allergic reactions may be associated with shock, hypotension and death. Moreover, we are informed from the previous history that this patient was known to have allergic phenomena. His previous attacks, however, were always associated with cutaneous manifestations, which were absent here. Allergic diseases, according to Joslin, are as common in diabetics as in the general population. However, I do not believe that this patient's death can be ascribed to an acute anaphylactic reaction.

Addison's disease should be considered next. One is tempted to make this diagnosis in a patient whose skin was pigmented, who had a low blood pressure, who suffered shocklike states following upper respiratory infection and urticaria and responded well to intravenous saline injection. Yet there is little concrete evidence for Addison's disease and no hints are given us as to buccal pigmentation, or response to specific therapy used throughout the years.

The association of Addison's disease and diabetes is exceptionally rare. Thorn and Clinton[2] have collected 11 cases in the literature. They describe a case of Addison's disease in whom, at the onset of diabetes, the flattened glucose tolerance curve became more normal. A second larger group was diabetic, and later developed Addison's disease. This group was characterized by a diminishing requirement for insulin as the Addison's disease progressed. Little is known of the insulin requirement in our patient, particularly if it diminished as the years progressed. If such was the case one might play with the idea of Addison's disease complicating the diabetes. Yet the rarity of the two associated conditions, the long life of the patient, and the absence of more definite criteria for the diagnosis of Addison's disease, tend to exclude it as a possibility.

HEMOCHROMATOSIS

Finally, let us consider hemochromatosis. Here was a patient in whom hepatomegaly, diabetes, and pigmentation were all present. Moreover he was middle-aged and of the male sex, the usual findings in this disease. Its rarity in the female is commented on by all observers. Other helpful signs were not mentioned. Splenomegaly is usual in hemochromatosis and testicular atrophy, loss of libido and scanty hair are common signs stressed by many. Priscilla White[1] in elaborating upon this phase of the disease recorded extremely low levels of 17-ketosteroid excretion in several cases.

Moreover Shelton,[3] who has written a definitive monograph on hemochromatosis, described two autopsied cases in whom both the pituitary gland and the adrenal cortex, particularly the glomerular portion of the latter, were infiltrated by hemosiderin pigment. Both Shelton and Joslin commented on the low blood pressure which is common in this disease, and remarked that this finding coupled with cutaneous pigmentation has often misled the clinician into making a mistaken diagnosis of Addison's disease.

Butt and Wilder[4] in discussing the association of hemochromatosis with Addison's disease noted that involvement of the pituitary gland with infiltration of pigment was so common that secondary adrenal failure could be expected just as in Simmonds' disease. In certain cases both the pituitary and adrenal glands were infiltrated by pigment and secondary adrenal insufficiency was therefore complicated by actual destruction of the adrenal cortex itself.

Abdominal pain is common in the terminal phases of hemochromatosis. Darnall[5] described in detail a case which closely resembled the present patient. His patient, a male, was admitted with the findings of abdominal pain, hypotension, shock and pneumonia. Coma and death followed rapidly after the patient failed to respond to adrenal cortical extract and intravenously administered saline. Autopsy revealed not only cirrhosis and pigmentation of the liver, pancreas and spleen, but also involvement of the pituitary and adrenal glands.

PITFALLS IN DIAGNOSIS

However, before we can conclude that ours was a case of hemochromatosis let us consider certain pitfalls in the diagnosis. Diabetes usually follows the more obvious signs of hemochromatosis as the pancreas becomes laden with the pigment. It is commonly one of the terminal episodes in the clinical picture. Butt and Wilder report one case, however, who survived 13 years after the initial symptoms of diabetes became manifest. Allergic states as described in this patient have been reported in patients with hemochromatosis.[6] Finally, the absence of a positive skin biopsy makes one hesitate momentarily. Shelton, however, mentioned that 20 per cent of autopsied cases failed to reveal a positive skin biopsy. John[7] described in detail a proved case with a negative skin biopsy, and Darnall recorded one case in whom the first biopsy was read as negative and the second as positive. Thus, although one would prefer a positive skin biopsy, its absence cannot definitely exclude the diagnosis of hemochromatosis.

In conclusion, therefore, I believe that this patient had hemochromatosis with involvement of the liver, spleen, pituitary gland and glomerular portion of the adrenal cortex. The terminal episode was due to acute adrenal insufficiency, the result of failure of function of the adrenal cortex. There was probably also secondary adrenal insufficiency due to deficiency of the pituitary gland. Diabetic acidosis complicated the adrenal failure but was a terminal episode only.

CLINICAL DIAGNOSIS

1. Hemochromatosis with involvement of the liver, spleen, pituitary and adrenal cortex.
2. Acute adrenal cortical insufficiency.
3. Terminal diabetic acidosis.

GENERAL CLINICAL DISCUSSION

DR. WILLIAM F. ASHE: What was your interpretation of the areflexia below the diaphragm level?

DR. GLUECK: I more or less disregarded that. One may see areflexia in any type of shock.

DR. EUGENE B. FERRIS: What is the mechan-

ism of the shocklike state in these cases? Is it related to disease in the region of the hypophysis and the floor of the third ventricle?

DR. GLUECK: Wilder and Darnall stated that the mechanism of adrenal insufficiency may be due to primary pituitary involvement or due to deposit of iron pigment in the adrenal cortex itself.

DR. FERRIS: Do you attribute the earlier shocklike episodes to the same mechanism?

DR. GLUECK: Yes, I think he had subclinical adrenal cortex insufficiency for many years with precipitation into overt deficiency each time he suffered from a mild infectious disease. It is of some interest, I think, that he responded so well each time to the administration of sodium chloride.

DR. STANLEY E. DORST: Although Dr. Glueck has put the manifestations in this patient together so well, I think we should keep in mind that this picture can also be produced by staphylococcus toxin. He may well have suffered terminally from acute food poisoning.

PATHOLOGICAL DIAGNOSIS

1. Hemochromatosis with extensive involvement of the glands of internal secretion:
   a) Pigmentary cirrhosis of the liver.
   b) Diffuse iron deposition in the pancreas, adrenal cortex and thyroid.
2. "Adreno-status-thymus-lymphaticus":
   a) Atrophy of adrenal cortices.
   b) Generalized lymphoid hyperplasia.
   c) Small heart.
   d) Female hair distribution.
3. Probable terminal septicemia:
   a) Acute tracheitis, mediastinal lymphangiitis, lymphadenitis and beginning cellulitis.
   b) Beginning aortic valvular bacterial endocarditis.
   c) Acute focal peritonitis.

PATHOLOGICAL DISCUSSION

DR. PEARL M. ZEEK: The embalmed body was examined 10 hours after death. It appeared to be that of an individual at least 10 years younger than the stated age of 59 years. The only other external findings of note were an unusually fine-textured skin and a feminine type of hair distribution, the hair being absent on the chest, sparse and silky in both axillae and terminating in the suprapubic region in a straight transverse line.

The visceral pathological changes were associated with three disease processes: (1) hemochromatosis, which was far-advanced and long-standing, (2) a terminal infection of short duration, and (3) adreno-status-lymphaticus.

Hemochromatosis was manifested by the deposition of large amounts of iron pigment in the epithelium of the liver, pancreas, thyroid and adrenals, and in the regional lymph nodes. There were smaller amounts in the heart muscle, renal tubular epithelium (upper nephron), and in the stroma of the spleen and other viscera. No iron was found in one section of skin. The pituitary was not studied because of refusal to permit examination of the cranial cavity.

THE LIVER

The markedly enlarged, diffusely nodular, bronze-colored liver weighed 2725 Gm. and presented typical pigmentary cirrhosis. Both the liver and pancreas were diffusely loaded with iron. The deposits in the adrenals were in the glomerular zone of the cortex. The adrenals appeared to be about normal in size, although there was the marked congestion usually associated with shock. Microscopically there was atrophy of the heavily pigmented glomerular zone and focal degeneration of the fascicular zone. In the thyroid many of the acini were small with absent or poorly stained colloid. The acinar epithelium contained iron pigment.

The hormonal imbalance to be expected with lesions such as these in the glands of internal secretion was probably the cause of the clinically manifested diabetes, hypotension, shocklike episodes and possibly also a decreased ability to respond to infection.

In this case there were also the morphological changes associated with so-called adreno-status-thymo-lymphaticus. All lymphoid structures, including Peyer's patches and the solitary follicles of the gastro-enteric tract, were enlarged and microscopically showed follicular hyperplasia. The substernal fat pad overlying the pericardium contained more than the usual remnant of thymic tissue. The adreno-cortical atrophy has been mentioned. The heart was small, weighing only 280 Gm. (the normal weight for a man of this body length being 327 ± 40), and in this case the heart weight was increased somewhat by the iron deposits in the myocardium. Another characteristic of this syndrome was the feminine hair distribution. The usually associated testicular atrophy was not detected grossly. Sections were not taken.

SEPTICEMIA?

The terminal infectious process was probably streptococcus septicemia, although embalming prevented proof by culture. Petechiae mottled the pleurae and the serosal surface of the esophagus. One small rough nodule protruded from one cusp of the aortic valve. There were 100 cc. of cloudy fluid in the pertioneal cavity. Microscopically, the lesion on the aortic valve was a very early endocarditis with beginning infiltration of neutrophils and small groups of cocci, the latter occurring in pairs and short chains. Gram stains were inconclusive due to embalming, but the morphology of the organisms suggested streptococci.

Similar organisms were found microscopically

in a few small foci of fibrinopurulent peritonitis and in the peri-esophageal region, which in addition to small hemorrhages presented infiltration of the lymphatics and loose areolar tissues with neutrophils. These lesions were between the trachea and the esophagus. The former presented early inflammatory changes, the latter had a normal appearing mucosa. No pneumonia was found microscopically, although at autopsy portions of both lungs, especially the left, appeared subcrepitant.

The above findings leave uncertainty as to the portal of entry, but because of the mediastinal lymphatic involvement it was probably either esophageal or tracheal.

Rapidly fatal infection with minimal lesions is not uncommon in patients whose hormonal imbalance leads to inadequacy of the so-called "alarm reaction." In this case such an explanation of the mode of death is consistent with both the clinical and pathological findings.

The relationship in this case between hemochromatosis and adreno-status-thymo-lymphaticus must remain conjectural. The latter combination of characteristics has long been considered familial, but in some cases has not been recognized clinically until adulthood. The age of onset of hemochromatosis is unknown but its insidious beginning is surely many years before clinical recognition. Various endocrine disturbances have long been recognized as part of the clinical picture of hemochromatosis, although most textbooks stress diabetes, and more recently, testicular atrophy to the exclusion of other endocrine manifestations. The basic etiology of hemochromatosis remains unknown.

GENERAL DISCUSSION

Dr. Johnson McGuire: I must repeat that saline administered intravenously was a specific remedy in this patient. This was an important feature which was demonstrated repeatedly throughout his course. Incidentally, he did have testicular atrophy and complained of loss of libido. He attended a party just before the onset of his illness and may have gotten some contaminated food. There was, however, no illness among the other guests. The rapidity of his terminal illness was remarkable. He died within a matter of hours after the onset of symptoms.

Dr. Ferris: Could the peritracheal lesions have been less than 24 hours old?

Dr. Zeek: Yes, indeed.

Dr. Leon Schiff: Are there any new ideas on the pathogenesis of hemochromatosis?

Dr. Zeek: Not that I know of.

Dr. Richard W. Vilter: May hemochromatosis result from multiple transfusions?

Dr. E. A. Gall: We have discussed that possibility several times before. I do not believe that any such relationship has ever been conclusively proved. Hemosiderosis may occur, but I don't think that hemofuscin is produced in significant amounts nor does the pigment deposit result in the scarring seen in hemochromatosis. I believe, however, that those cases showing hemosiderosis following multiple transfusions do have some disorder of pigment metabolism or iron utilization. Under normal circumstances I think the iron could be picked up very rapidly.

Dr. Schiff: Dr. T. B. Mallory told me that he had never seen an instance of cirrhosis follow the deposition of hemosiderin in the hemolytic syndromes.

Dr. Henry Felson: Was this patient sensitive to insulin?

Dr. McGuire: He had large doses, 120 units a day. I don't believe there were any hypoglycemic episodes.

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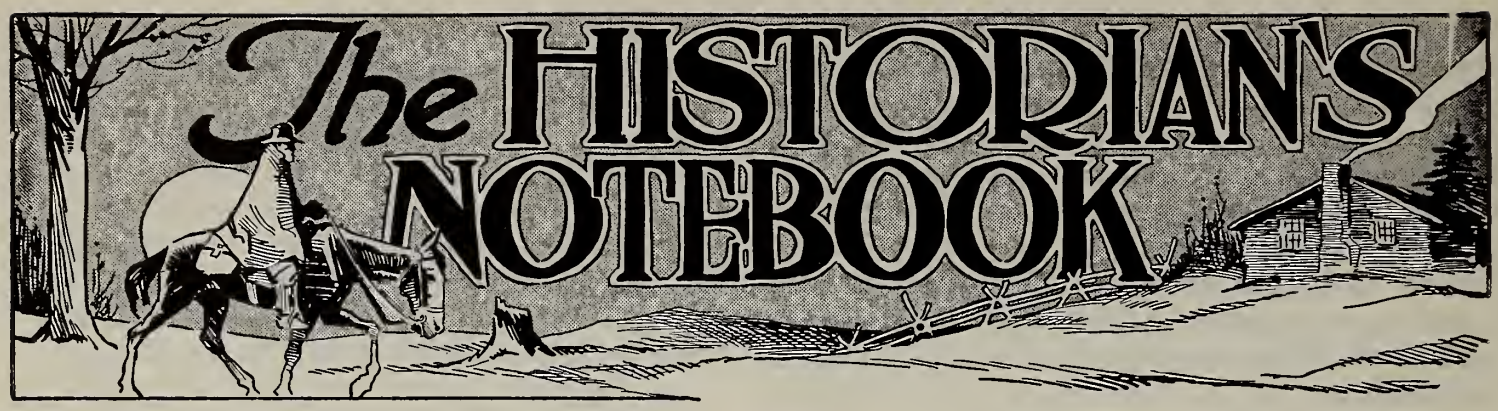
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The Serum Complement Titer In Rheumatoid Arthritis

The serum complement titer has been measured in rheumatoid arthritis and several of the other collagen diseases as well as glomerular nephritis. It has been found to be depressed in acute glomerular nephritis, lupus erythematosus disseminatus, serum sickness and certain experimental antigen antibody reactions both in vitro and in vivo.

In rheumatoid arthritis and rheumatic fever however, it is strikingly elevated. This would suggest that we are not dealing with an immunological response in the case of rheumatic fever and rheumatoid arthritis were it not known also that certain antigen antibody reactions do not fix complement. In addition, allergic reactions caused by simple chemical antigens and whose clinical manifestations are similar to serum sickness were found to have a high complement titer.

Because immunologic or allergic reactions may occur without apparent fixation or diminution in complement, the possibility remains that the rheumatic process may be allergic and yet fail to fix complement. Thus study of complement has neither refuted nor supported the allergic concept.—Arthur M. Phillips, M. D., Roswell W. Phillips, M. D., and Wendell T. Caraway, Ph. D., *Rhode Island Med. J.*, 35:610, November, 1952.



Sectarian Medicine in Ohio

FREDERICK C. WAITE, Ph.D.

BOTANIC MEDICINE (THOMSONIANISM)

SECTARIAN medicine in Ohio arose from three main stems: Thomsonianism, reformed botanic medicine, and homeopathy. Samuel Thomson (1769-1843), an illiterate farmer and blacksmith of western New Hampshire, began about 1800 to administer decoctions of lobelia to members of his family to which he soon added steam baths. He evolved a system of treatment about 1808 that he named botanic medicine which came to be commonly called Thomsonianism. The composition of the remedies was kept secret for twenty years being designated by numbers from one to six. The major procedures of the system were emesis, purgation, and steam baths.

A Federal patent was secured in 1813 and renewed in 1823. Thomson sold the right to use this patent. A pamphlet first published in 1812, after several revisions and extensions, appeared in 1822 as a duodecimo volume of 180 pages published in Boston under the title of *A Narrative of the life of Samuel Thomson containing an Account of his System of Practice.* This was written by an associate from dictation by Thomson who could neither read nor write. The content was mainly claims of curing patients of serious diseases which were largely falsely diagnosed, being in fact simple ailments. Exaggerated claims form the essence of quackery.

A companion volume was soon published with the title *New Guide to Health and Botanic Family Physician.* These two volumes, with abridgment of the first, were combined into a single volume which went through eighteen editions. Each copy of the book contained an engraved certificate giving the purchaser the right to practice the patented botanic system. The botanics called this a diploma. The price of the book with the contained certificate was twenty dollars.

The earliest record of Thomsonianism in Ohio is that Cyrus Thomson, a son of Samuel, was in botanic practice in northern Ohio prior to 1821. Ohio received large migrations from eastern states in the third decade of the nineteenth century and the population of the state increased 60 per cent between 1820 and 1830. Many of these migrants were adherents of Thomsonianism.

Samuel Thomson conducted his business from his home in Boston by appointing agents to sell his book, rights to use his patent, and the medicaments manufactured under his direction. The first agent in Ohio was appointed in 1825. Thomas Hersey became agent in 1827 and was located at Columbus, which became the administrative center of Thomsonianism for all the western country. Samuel Thomson made annual visits to Ohio beginning in 1827 and in that year the fourth edition of his book was published at Columbus. *The Thomsonian Recorder* was founded at Columbus in 1832 with Hersey as editor and became the leading journal of the cult. Thomson and Hersey parted in 1834 over financial matters and Alva Curtis became agent and editor.

Alva Curtis (1797-1881), born in New Hampshire and well educated, went to Richmond, Virginia, in 1829 as a private tutor. He was converted to Thomsonianism in 1831 and began practice. In the same year he began to advocate abolition of slavery and was no longer popular in Virginia and in 1832 moved to Columbus where he became the leading proponent of Thomsonianism in the West beginning in 1834.

He began in 1836 to give lectures to groups

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of students in what he called The College of Physicians and Surgeons. This brought a disagreement with Samuel Thomson who opposed any teaching of his system, claiming that possession of a copy of his book was the only necessity to practice his system. Curtis became the leader of a dissident faction under the name of The Independent Thomsonian Botanic Society and in 1838 changed the name of his journal to *The Botanico-Medical Recorder*. He secured a charter for his medical college in 1839 which was the first chartered Thomsonian medical college in the United States. He moved his journal and college to Cincinnati in 1841 and renamed the college The Botanico-Medical Institute.

PHYSIOMEDICALISM

Samuel Thomson died in 1843 and his followers divided into several factions, one taking the name of true Thomsonians and another the name of physiomedicalists. The word "botanic" became unpopular and in 1850 Curtis changed the name of his journal to *Physio-Medical Recorder* and of his college to Physio-Medical College. The adjective "botanic" was thereafter applied only to the remnants of the true Thomsonians.

A rival medical college was organized in Cincinnati in 1859 with the name Physio-Medical Institute. These two rivals became weak and one or the other was suspended at intervals. One of them became extinct in 1880 and the other in 1885.

Thomsonianism reached its peak in Ohio before 1840. Samuel Thomson claimed in 1835 that one-third of the population of Ohio, then about 1,300,000, were adherents of his system and the regular profession conceded one-fifth. At this time a firm in Cincinnati was the leading producer of Thomsonian medicaments in the United States.

REFORMED BOTANIC MEDICINE AND ECLECTICISM

The second stem of sectarian medicine in Ohio arose independently of Thomsonianism. Wooster Beach (1794-1868), born in Connecticut, was well educated and a teacher in academies. He attended one session in a medical college in New York City and was licensed to practice by a regular medical society. He became acquainted with a herbalist in New Jersey and adopted the use of plant remedies under the name of reformed botanic medicine. He was violently opposed to Thomsonianism and did not use the word "botanic" after 1830. He called himself a reformer as did his followers.

He established in New York City in 1826 an institution to teach his system under the name of Reformed Medical College. Failing to secure a charter in New York he moved to Ohio. An Episcopalian college existed at Worthington, nine miles north of Columbus, from 1818 to 1822 and when it closed, left a good building. Under an amendment to its charter, Beach and his associates in 1830 founded the Reformed Medical Department of Worthington College, usually called Worthington Medical College.

Alva Curtis, leader of the Thomsonians in Columbus, attacked the group at Worthington in his journal *The Thomsonian Recorder*. The group at Worthington in 1836 founded *The Western Medical Reformer*. A violent controversy followed in the two journals. The institution at Worthington began to decline in 1838, partly as a result of this controversy, and the legislature revoked the charter in 1840 after the conferring of about 100 degrees of Doctor of Medicine, many of them honorary.

The two antagonistic groups were known as Beachites and Curtisites. Curtis moved to Cincinnati in 1841, as already stated, and in 1842 the Beachites followed, reviving their journal and their college under the name of The Reformed Medical College of Cincinnati. Efforts to secure a charter failed until 1845 when a charter was obtained under the name of Eclectic Medical Institute. The word "eclectic" had been applied to a medical cult in Rome in the first century of the Christian Era. The modern eclectics claimed to select the best from all systems of medical practice.

Thus both stems of sectarianism were located in the same city. The eclectics stressed the claim that they were reformers and under aggressive leadership began to gather strength while the physiomedicalists declined. Complete statistics are not available as to the number of graduates of the botanic and physiomedical colleges before the last one in Ohio closed in 1885, but probably fewer than 800. However, the eclectic institutions graduated more than 3,750 men and women in Ohio up to 1900 and extended to more than 4,800 by 1939. Eclecticism developed from reformed botanic medicine and Wooster Beach is acknowledged as its father.

HOMEOPATHY

The third group of sectarians in Ohio were adherents of homeopathy, a word coined by Samuel Hahnemann (1755-1843), an educated regular physician in Germany, when he published his first book in 1810 under the title of *Organon der rationellen Heilkunde*. The first practitioner of this sect in the United States came from Europe to New York City in 1825.

The first record of a homeopath in Ohio was at Cleveland in 1845. A call was issued in 1849 for a convention of "all homeopaths of the West." Seven men attended, all residents of northern Ohio. This meeting advocated founding of a homeopathic college in Ohio. The eclectics sought to absorb this new rival in the state by creating a professorship of homeopathy in the Eclectic Medical Institute which continued for one session and then was abolished with violent

accusations between the few homeopaths and the eclectics. These two groups were adversaries during the next 50 years.

The Western College of Homeopathic Medicine was chartered and began instruction in Cleveland in the fall of 1850. A reliable local historian of homeopathy wrote that there were about 50 homeopaths in Ohio at that date. All were homeopaths by self-proclamation, with their only knowledge of the system coming from reading an English translation of the *Organon.*

The growth of homeopathy was preponderantly in the northern part of the state until a homeopathic medical college was founded in Cincinnati in 1872. The distribution of homeopaths continued to be mainly in the northern half of the state during the nineteenth century while the majority of the eclectics were in the southern half of the state.

Homeopathy progressed during about 30 years. The peak of popularity of the sect in Ohio came in the late 1870's. Decline began about 1880 coincidently with improvement in regular medicine, both in its practice and its educational program. Eclecticism also began to decline at this time. Physiomedicalism was already moribund. Decline was accentuated after 1900. Only one homeopathic medical college existed in Ohio after 1910 and with meager attendance became extinct in 1922. The total number of graduates of homeopathic medical colleges in Ohio in 72 years from 1850 to 1922 was 2,825 men and women.

HYDROPATHY

One subsidiary medical cult deserves mention. Hydropathy, the treatment of disease with cold water, originated in Germany with the first sanitarium opening in 1826. The cult reached the United States in 1843. Treatment was entirely in sanitaria, popularly called water cures. The first water cure in the United States opened in 1844 with two more in 1845, all in New York State. Water cures appeared in Ohio before 1850 with increase in numbers until 1870 and then rapid decline with none in operation in 1890. The practitioners were few with two or three in each water cure. The directory of 1900 lists only one hydropath in Ohio.

Several minor medical cults appeared in Ohio in the last quarter of the nineteenth century. Each was ephemeral and had few adherents. They are not of sufficient importance to list their names.

STATISTICAL

Sources are few and incomplete for estimate of the number of sectarians in Ohio and their proportion of all practitioners in the state in the nineteenth century. The unreliability of claims of the sects is illustrated by the assertion that 1,000 men and women were practicing homeopathy in Ohio in 1885 while the directory of 1886 listed fewer than 500. It is improbable that more than 800 homeopaths were in practice in Ohio at any one time.

The United States census began in 1850 to enumerate the number of physicians in each state but did not designate systems of practice. The only remaining source is medical directories which indicated by symbols the system of medicine of each physician listed. To secure statistics of the number of sectarians in practice in Ohio in different years I have checked for symbols of practice more than 63,000 names in nine directories of all physicians in Ohio extending from 1877 to 1950.

The first national medical directory was published in 1874 with an improved edition in 1877. National directories were published in 1886, 1890, 1894, and 1898 but do not lend themselves to accurate statistics because symbols show that in each of these more than one-fourth of the physicians in Ohio failed to reply to inquiries sent to them by the compilers. Therefore statistics through 1899 must be largely conjectural. Several sources of information, including directories of the larger cities of the state, indicate that in 1880 nearly 1,200 sectarians were in practice in Ohio comprising approximately one-fourth of all physicians of Ohio. This is a conjecture and does not deserve to be called an estimate.

The first fairly complete medical directory of Ohio was published in 1900 after the records of the Board of Medical Examination and Registration had become available. A symbol of the system of practice is attached to all of the 6,216 names except ¼ of 1 per cent. This directory shows 1,162 in sectarian practice or nearly 19 per cent of all physicians in the state. The distribution was: 769 homeopaths, 342 eclectics, 41 physiomedicalists, and seven of minor cults.

A directory of 1905 shows a decrease to 17 per cent as the proportion of sectarians. A directory of 1917 shows fewer than 1,000 sectarians in the state representing 13 per cent of all physicians in Ohio, a decrease of the proportion by approximately one-half since 1880. A directory of 1938 shows symbols of sectarian practice attached to only 160 names which was 1¾ per cent of all physicians listed in Ohio in that year. The directory of 1950 carries the names of 9,883 physicians in Ohio. Symbols indicating sectarian practice are attached to only 31 names which is ⅓ of 1 per cent of the total. Ten of these were not in practice. The distribution was 25 homeopaths, five eclectics, and one physiomedicalist. Osteopaths and chiropractors were not listed in medical directories after 1910.

The sectarians prominent in Ohio at the end of the nineteenth century had practically disappeared at the middle of the twentieth century or at least had ceased to lay claim to being

sectarians. However, two new breeds of cults had arisen.

CURRENT CULTS

Osteopathy was invented in Missouri in 1874 and a college to teach the cult was chartered in 1894. The first osteopaths invaded Ohio in the closing years of the nineteenth century. The directory of 1900 lists six of them, four in Cincinnati and two in Cleveland. Osteopathy received legal recognition in Ohio in 1902 and a medical directory in 1905 lists 43 in practice in the state. The educational program of osteopathy has shown improvement in the past 50 years. Statistics of steps of growth of this cult in Ohio are not readily available. There are 700 licensed osteopaths in Ohio in 1952.

Chiropratic was invented in Iowa in 1897 as an inferior offshoot of osteopathy. It was first given legal recognition in Ohio in 1915. Its educational program has shown meager improvement in 50 years. There are 400 licensed chiropractors in Ohio in 1952.

This total of 1,100 of these two cults approaches the number of sectarians in Ohio in 1900. The total number of those who treat the sick in Ohio has increased about 60 per cent in 50 years. Therefore the proportions of all who treat the sick in Ohio comprised by these two cults is about 11 per cent compared to 19 per cent for the sectarians of 1900.

DECLINE OF EARLY SECTARIANISM

The popularity of sectarian practitioners waned in the early decades of the twentieth century in Ohio when it became known to the general public that regular physicians were much better trained than were the sectarians. This resulted in a policy among sectarians that influences statistics. Some sectarians began before 1920 to omit in their replies to compilers of medical directories the fact that they were sectarians. They preferred to be recorded only as physicians with the implication that they were regular in their practice.

I have checked two directories of all physicians in Ohio to secure data on this policy among the graduates of one prominent sectarian medical college in Ohio. The directory of 1917 lists 318 names to which are attached the symbol denoting practice of eclecticism, while the symbol is omitted from the names of 49 graduates of the Eclectic Medical Institute and College. This policy was also used by the homeopaths less extensively than by the eclectics.

Statistics of the growth of this policy is taken from the directory of 1938 which shows in Ohio only 46 names of physicians to which are attached the symbol indicating practice of eclecticism. In contrast the symbol is omitted from the names of 326 graduates of the Eclectic Medical Institute and College. Eighty of this number were residents of Cincinnati, the fountain head of eclecticism, while only eight names in that city bear the designation that they were eclectics. Moreover, of the total of 326 names those of 100 show the designation that they were members of the American Medical Association which shows total abjuration of sectarian practice. These statistics of 1938 indicate that the practice of eclecticism in Ohio was moribund a year before its last medical college became extinct in 1939.

At least 8,300 men and women have received the degree of Doctor of Medicine from sectarian medical colleges in Ohio in the proportion of about 4,800 eclectics, 2,800 homeopaths, and 700 botanics and physiomedicalists.

Ohio has been sorely beset by medical cults and sects during more than a century and a quarter and the history of medicine in Ohio is incomplete without a brief survey of sectarian medicine in the state.

Sesquicentennial Engagement Calendar

1803 - Ohio - 1953, Sesquicentennial Year Book with Historical Notes and Pictures, sponsored by The Martha Kinney Cooper Ohioana Library Association, 1109 Ohio Depts. Bldg., Columbus 15, Ohio., ($1.25. *The World Publishing Co., 2231 W. 110th St., Cleveland 2, Ohio).* This interesting and attractive engagement calendar shows the painstaking work of many Ohio contributors, edited by Mrs. Depew Head (Florence R. Head).

Stevan Dohanos, noted Ohio artist, designed the cover which pictures against a silhouetted map of Ohio, the frontiersman, American Indian, the stockade and the flintlock, the Ohio River steamboat, Thomas Edison's light bulb, Wright Brothers' airplane—all artistically suggestive of Ohio's Sesquicentennial years. On the back cover is depicted the Great Seal of the state.

Opposite blank pages ruled for entries each day of 1953, appear a wealth of historical notes, beautiful reproductions in sepia of paintings, photographs, and places of interest, and a closing tribute, "Our Ohio," by Daniel Francis Clancy. The book opens flat with an interlocking white plastic fastener and comes enclosed in carton for convenient addressing and mailing.

Hippocrates: **On Intercourse and Pregnancy.** An English Translation of "On Semen" and "On the Development of the Child," by Tage U. H. Ellinger, Sc. D., M. A., with an Introduction by Alan E. Guttmacher, M. D., ($2.50. *Henry Schuman, Inc., 20 E. 70th St., New York).*

Here is, whatever its authorship, a clear statement of the theories of reproduction, embryology and heredity as they were held in the fifth century before Christ. Non-technical, of course, all will enjoy it as a most unusual experience.

Proceedings of The Council . . .

Important Items of Business Transacted at Meeting on December 14; Budget for 1953 Adopted; Committee Reports Presented and Approved

A MEETING of The Council of the Ohio State Medical Association was held in the Columbus office on Sunday, December 14, 1952. All members of The Council were present except Dr. McAfee and Dr. Meiling. Others attending were: Dr. C. C. Sherburne, Columbus, an A. M. A. delegate; Dr. H. P. Worstell, Columbus, chairman of the Committee on Industrial Health and Workmen's Compensation; Dr. Robert Conard, Wilmington, chairman of the Military Advisory Committee; and Messrs. Nelson, Saville, Page and Moore.

On **motion** duly made, seconded and **carried**, The Council approved the minutes of the Council meetings held on September 26, 27, 28, 1952, at Granville, Ohio.

MEMBERSHIP FIGURES

The Executive Secretary reported membership figures as follows: Total membership of the State Association as of December 12, 1952, 7,804, including 135 military members; compared to a total membership of 7,663 as of December 31, 1951. Also, he reported to The Council on A. M. A. membership as follows: Total number of Ohio physicians holding 1952 membership in the American Medical Association, 6,411, including 113 military members and 233 non-dues-paying members under the age exemption provision; number of Ohio physicians belonging to the American Medical Association in 1951, 6,216; percentage of 1952 O. S. M. A. members belonging to the A. M. A., 83.67.

WAIVER FOR MILITARY MEMBERS

On **motion** duly made, seconded and **carried**, The Council adopted the following policy, providing for the waiver of 1953 membership dues for members of the Association now on military duty on a temporary basis as a result of the present national emergency and authorizing the waiver of 1953 membership dues for members entering the service 1953:

"1. State Association dues for 1953 shall be waived for members now on active military duty on a temporary basis and as a result of the present national emergency.

"2. State Association dues for 1953 shall be waived for physicians who were members of the Association in 1952 and who enter active military service during the calendar year 1953 before the payment of 1953 dues.

"3. A refund of membership dues will not be made if a member enters military service in 1953 after his 1953 dues are received at the Columbus office of the Association.

"4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions."

AMENDMENTS APPROVED

A new constitution and by-laws adopted by the Erie County Medical Society on October 23, 1952, was reviewed by The Council and on **motion** duly made, seconded and **carried**, was approved.

Amendments to their constitution and by-laws, submitted by the Tuscarawas County Medical Society on November 23, 1952, and by the Trumbull County Medical Society on October 17, 1952, which had been approved by those societies, were approved by The Council on **motion** duly made, seconded and **carried**.

HEART DISEASE CLINICS

A request from Dr. Lillian Marks, Medical Director, Services for Crippled Children, Division of Social Administration, for approval of diagnostic clinics for children with heart disease, and which had been held pending, was considered. Information received from officials of the county societies in Fayette County and Greene County, where such clinics have been conducted, was reviewed. This information indicated that the county medical societies of those counties and the physicians of the counties had approved the holding of the clinics and that the physicians considered these clinics of real value both to them and to the patients examined. On **motion** duly made, seconded and **carried**, The Council voted approval of such clinics, providing (1) they have the approval of the county medical society of the area in which the clinics are to be held; and (2) providing such clinics are conducted in line with the same policies used in the administration of the clinics in Fayette and Greene Counties. In taking this action, The Council expressed the hope that if such clinics are to be continued that at an early date local and state funds could be made available to finance them rather than Federal funds.

The Council then went into executive session for the purpose of considering the annual report of the Committee on Auditing and Appropriations and the treasurer.

By unanimous action, The Council approved

the report and recommendations of the committee, including the following budget for 1953:

BUDGET FOR 1953

The Ohio State Medical Journal		$ 25,000.00
Executive Secretary, Salary		12,260.00
Executive Secretary, Expense		2,000.00
Stenographic-Clerical Salaries		20,500.00
President, Expense		1,000.00
Council, Expense		3,000.00
A. M. A. Delegates, Expense		3,500.00
Department of Public Relations (see below)		34,620.00
Director, Salary	$10,520.00	
Director, Expense	2,000.00	
Asst. Director, Salary	6,100.00	
Asst. Director, Expense	1,500.00	
Exhibits and Newspaper Publicity	2,000.00	
Literature	5,000.00	
Postage	2,000.00	
Supplies	500.00	
Miscellaneous Activities	5,000.00	
Committee on Education		250.00
Committee on Public Relations and Economics		500.00
Committee on Scientific Work		350.00
Committee on Auditing and Appropriations		300.00
Committee on Cancer		250.00
Committee on Industrial Health		500.00
Committee on Medical Care of Veterans		200.00
Committee on Medical Service Plans		500.00
Military Advisory Committee (see below)		6,500.00
Chairman, Salary	$6,000.00	
Committee, Expense	500.00	
Committee on Rural Health		2,000.00
Rural Medical Scholarships		2,000.00
Committee on Blood Banks		500.00
Committee on School Health		1,000.00
Committee on Chronic Illness		500.00
Miscellaneous Committees		300.00
Annual Meeting		16,000.00
Conference County Society Presidents-Secretaries		2,000.00
Postage		2,000.00
Telephone and Telegraph		2,500.00
Professional Relations Activities		6,000.00
Rent		7,349.52
Insurance and Bonding		2,600.00
Stationery and Supplies		3,000.00
Employees' Retirement Fund		4,057.61
Legal Expenses		1,500.00
Contingent Unassigned		6,032.87
		$170,570.00

WORKMEN'S COMPENSATION

Dr. H. P. Worstell, chairman, reported to The Council on business transacted on October 26, 1952, by the Committee on Industrial Health and Workmen's Compensation. The following recommendations of the committee were approved by The Council:

1. That the State Industrial Commission be requested to revise its Medical and Surgical Fee Schedule to provide that an assistant to a surgeon be paid a fee equivalent to 20 per cent of the fee allowed the surgeon, the minimum fee to be $10.00.

2. That the State Industrial Commission be requested to add the following question to its Form C-19 (Attending Physician's Fee Bill):

> "If flat fee case, did you render all after-care? If not, name physician who did."

This suggestion was made by the committee so the Commission would know whether or not a physician other than the surgeon is rendering after-care or would be requested to render after-care by the surgeon, thus enabling the Commission to make an equitable apportionment of the flat fee allowed for the case under the fee schedule.

3. That the State Industrial Commission be requested to adopt a new rule, reading as follows:

> "A physician other than the operating surgeon, who renders the after-care in a flat fee case, shall be paid in accordance with Rule No. 6. A physician who refers a case for surgery and who does not render surgical after-care shall be entitled to a fee for hospital visits, not to exceed five unless otherwise authorized."

4. That the item in the Fee Schedule regarding blood or plasma transfusion be changed to read as follows:

> "When blood or plasma transfusion is given by a physician, he shall be paid a fee of $5.00 in addition to the fee for a hospital visit, but no fee shall be paid when a transfusion is given during an operation."

5. That The Council approve a proposal that the Committee on Industrial Health and Workmen's Compensation give early consideration to the matter of adopting recommended revisions in the Medical and Surgical Fee Schedule of the State Industrial Commission and that the Ohio Academy of General Practice, members of specialty groups, county medical societies, and the membership generally be requested to prepare what they would consider as equitable revisions in the fee schedule and to submit such proposals to the committee at the earliest possible date.

In approving the foregoing specific recommendations of the committee, The Council also approved actions taken by the committee on a number of specific problems which had been presented to the committee for review and for discussions with representatives of the Commission.

Following the vote approving the report and recommendations of the Committee on Industrial Health and Workmen's Compensation, The Coun-

cil adopted a subsequent motion that the recommendations which had been approved should not be submitted to the Industrial Commission until the committee has completed its work with respect to other proposed revisions in the fee schedule of the Commission.

MEDICAL CARE OF VETERANS

The Executive Secretary reported on behalf of the Committee on Medical Care of Veterans. The report in substance was as follows:

A meeting of the Committee on Medical Care of Veterans was held in the Columbus office on Sunday, November 9, 1952.

The following members of the committee were present: Dr. Drew L. Davies, Columbus, Chairman; Dr. L. D. Allard, Portsmouth; Dr. Robert L. Eastman, Mt. Vernon; Dr. W. W. Green, Toledo; Dr. Edgar Northrup, Marietta; and Dr. H. M. Clodfelter, Columbus, the president. Others attending were: Dr. Harvey H. Musser and Dr. A. H. Kyriakides, Akron, representing the Summit County Medical Society; Dr. H. P. Timberlake and Dr. Paul G. Hansen of the Cleveland Regional Office of the Veterans Administration; Dr. E. J. Geiser and Mr. Robert Fitzgerald of the Cincinnati Regional Office of the V. A.; and secretaries Nelson and Saville.

Dr. Davies, the chairman, pointed out that the purpose of the meeting was to consider the resolution, adopted by the House of Delegates at the 1952 Annual Meeting and subsequently referred by The Council to this committee, reading as follows:

"WHEREAS, The fee schedule of the Veterans Administration for the physicians of Ohio has not been adjusted since 1949, and

"WHEREAS, The present fee schedule is lagging behind the adjusted fee schedules of other organizations, and

"WHEREAS, There has been no fee included in the past for the voluminous record completion for services involved, and

"WHEREAS, there is an insufficient differential for the examining of patients in the home and in the office,

"THEREFORE, BE IT RESOLVED, That the Summit County Medical Society instruct its delegates to the Annual Convention of the Ohio State Medical Association in Cleveland, Ohio, to request The Council of the Ohio State Medical Association and its Committee on Veterans Administration to discuss and recommend an equitable fee increase for examination, treatment and preparation of the voluminous records requested by the Veterans Administration to complete a case."

Dr. Davies requested Dr. Musser to discuss the resolution. Dr. Musser pointed out that, inasmuch as the V. A. Fee Schedule effective in Ohio had not been revised, except in one or two instances, during the past three or four years, it was the belief of the Summit County Medical Society that certain items should be increased because of increased costs which now confront members of the medical profession. He stated that in all probability changes should be confined primarily to the fees for "visits" and "examinations." Dr. Musser also discussed the forms used by the V. A. as well as certain procedures.

Representatives of the Cleveland and Cincinnati offices of the Veterans Administration took part in the discussion with respect to forms and procedures. Following their discussion, it was the general opinion of the committee that the forms now used are satisfactory, that the paper work had been simplified to a large extent, and that in general the procedure used by the regional offices in their relationship with physicians is satisfactory.

A suggestion that physicians be allowed a specified amount for filling out reports on treatments was not approved by the committee. It was felt that this would not be feasible from an administrative angle. However, the committee felt that if certain fees were increased this would provide reasonable allowance for the paper work involved.

The committee then considered certain items in the fee schedule and by appropriate action voted to recommend to The Council that it request the following changes in the fee schedule:

Item 0011—Examination to determine need of hospitalization—$3.00 present fee):

(Proposed new fees)—Office **$5.00**
Home **$7.50**

Item 0012—Complete general routine physical examination including routine urinalysis:

Office ..... $ 7.50 (present fee)
Bedside ..... $10.00 (present fee)
(Proposed new fees)—Office **$10.00**
Bedside **$15.00**

In Item 0013 to Item 0022, inclusive, the **proposed new fees are shown in parentheses in the following:**

		Visits within city limits First			Subsequent	
Day—						
Office	0013	$3.50	**($5.00)**	0014	$2.50	**($3.00)**
Home	0015	$4.00	**($7.00)**	0016	$4.00	**(No Change)**
Hospital	0017	$4.00	**($7.00)**	0018	$3.50	**($4.00)**
Night—						
Home	0019	$7.00	**($9.00)**	0020	$7.00	**(No Change)**
Hospital	0021	$7.00	**($9.00)**	0022	$7.00	**(No Change)**

Item 0304—Biopsy, with report of histological examination—$10.00 (present fee):

(Proposed new fee) **$15.00**

Item 0305—Biopsy, (without report of tissue examination)—$5.00 (present fee):

(Proposed new fee) **$10.00**

Item 9110 — Laminagraphy — $15.00 (present fee):

(Proposed new fee) **$20.00**

The Executive Secretary advised the representatives of the Regional Offices that the Association would be very happy to carry articles in *The Journal* from time to time on procedures, forms, etc., for the information of the physicians of Ohio and specifically request them to submit information of this kind for publication.

The question of hearings in disputed cases was discussed. It was pointed out that The Council would name special local committees, in cooperation with the county medical society, to hold hearings on disputed cases when requested.

Doctors Timberlake and Geiser discussed letters which they are sending to physicians, pointing out that the funds for outpatient medical services and for services rendered by fee basis physicians have been drastically curtailed and requesting physicians to keep requests for authorization for treatment at a minimum; also, that they ask for authorization only for veterans requiring immediate care.

On **motion** duly made, seconded and **carried**, the foregoing report and recommendations of the committee were approved. The Executive Secretary was instructed to convey the recom-

mendations for changes in the fee schedule to the Washington office of the Veterans Administration, requesting official approval of the same.

PUBLIC RELATIONS

A report from the Committee on Public Relations and Economics, which committee had met in the Columbus office on November 16, 1952, was submitted by the Executive Secretary on behalf of that committee. The report, in part, read as follows, and on **motion** duly made, seconded and **carried**, was approved:

There was a general discussion of a resolution which had been presented to the House of Delegates at the 1952 Annual Meeting, and which had been referred to The Council for study and subsequently referred to this committee by The Council. The resolution read as follows:

"WHEREAS, It is generally recognized that hospitals are constantly overcrowded with unnecessary admissions, and

"WHEREAS, It is conceivable that prepayment hospitalization insurance programs contribute in a large part to this overcrowding, and,

"WHEREAS, It is a fact that prepayment hospitalization never does more than pay the per diem cost of hospitalization and does not provide the capital funds necessary to secure the additional beds demanded, and,

"WHEREAS, Private philanthropies can no longer be expected to provide the funds for these additional beds, and,

"WHEREAS, Government funds are the only remaining source to provide funds for these unnecessary admissions, and

"WHEREAS, It is our belief that this is and will henceforth be the most powerful source tending toward government control of the practice of medicine.

"THEREFORE, BE IT RESOLVED, that:

"(a) All hospitalization policies should contain a deductible clause and

"(b) Rewards should be granted for non-use of the benefits and

"(c) Certain illnesses for which hospitalization is not usually necessary should be deleted from the benefits of the contract and

"(d) Certain illnesses (injuries) not requiring inpatient care should be covered as outpatient to prevent unnecessary overloading of hospital facilities.

"It is further recommended that a copy of this resolution be forwarded to the Councilors of the Ohio State Medical Association and to the Board of Trustees of the American Medical Association and that they be asked to initiate action to correct these evils. It is also recommended that correspondence be carried out with the governing bodies of the insurance organizations most active locally with a view to determine their reaction to this resolution."

The committee decided to recommend to The Council that it request the Board of Directors or the Executive Committee of Ohio Medical Indemnity, Inc., to study the resolution and to submit its comments or recommendations to this committee at an early date. Also, it was suggested that perhaps representatives of O. M. I. could confer with representatives of the Blue Cross Plans on some of the questions raised in the resolution.

There was a discussion of recent opinions of the Attorney General of Ohio relative to the corporate practice of medicine by hospitals.

The committee was advised that The Council had requested it to make a study of the administrative procedures, rules, regulations, etc., of the medical and health program of the Division of Aid for the Aged. The committee felt that it would be advisable to secure information from the County Medical Societies before starting its study or before holding conferences with officials of the Division of Aid for the Aged. Therefore, it instructed the Executive Secretary to poll the County Medical Societies on behalf of the committee, requesting each society to send in criticisms and suggestions as to the operation of the Aid for the Aged medical and health program in their respective county. It was suggested that the communication be sent to the president and secretary of each society.

At 12:30 p. m. the committee adjourned to meet with a committee of the Ohio State Pharmaceutical Association at the Neil House. The two committees had dinner and then spent several hours in an informal discussion of mutual problems. It was decided that each association would designate a small committee to meet jointly for the purpose of compiling material for an article which could be published simultaneously in the publications of the two organizations. This article would endeavor to explain some of the misunderstandings which occur between the two professions and to answer questions which apparently are not understood by either physicians or druggists, or both. It was felt that after publication of this article, reprints in the form of leaflets could be distributed to members of both organizations, if the organizations cared to do so. Also, following the publication of the article, each organization could send a special bulletin to its local or district groups, suggesting local conferences between representatives of the two professions at which efforts could be made to further clarify mutual problems and to eliminate misunderstandings.

ANNUAL MEETING

The Council was advised by the Committee on Scientific Work that plans are progressing satisfactorily for the 1953 Annual Meeting of the Association in Cincinnati, April 21, 22 and 23.

By official action, The Council decided that the Association should invite the three Student A. M. A. Chapters in Ohio to send an official representative to the Annual Meeting at the expense of the Ohio State Medical Association and that a similar invitation should be extended to Mr. C. Craig Wright, senior medical student at Ohio State University and the first student to receive the Ohio Rural Medical Scholarship now being given by the Association to four students.

It was pointed out by a number of the Councilors that it would be desirable to hold the Annual Conference of County Society Presidents, Secretaries and Committee Chairmen in the Spring of 1953. After a general discussion, The Council approved a suggestion that this conference be held in Cincinnati on Monday, April 20, the day preceding the 1953 Annual Meeting, and that it consist of a luncheon to be followed by an afternoon program.

PUBLIC ASSISTANCE PROBLEM

A communication from a member on a problem relating to the care of a recipient of aid

for the aged, was reviewed by The Council. The communication pointed out that the Division of Aid for the Aged had refused to pay the physician for house calls made by his nurse, at which time penicillin was given and special bandages applied, on the grounds that it considered such visits as nursing care and that payment for nursing care is not permitted under Section 1395-3 of the General Code, which provides for the $200.00 per year additional allowance for medical, dental, optometrical and hospital services. After a lengthy discussion, The Council expressed the opinion (1) that since a nurse may not legally engage in the practice of medicine, charges for services which the nurse rendered in this case cannot be regarded as charges for medical services; (2) since the costs of nursing services are not covered by the law allowing a $200 additional benefit per year to old age pensioners for medical, dental, optometrical and hospital services, the Division cannot legally pay for the calls made by the nurse as in making such calls her services would have to be regarded as nursing services; and (3) a physician should keep in direct, personal contact with his patients and personally supervise the services performed by his nurse or other assistants which conditions were not followed in this case.

For these reasons The Council felt that it could not request the Division to pay the fees charged in this case. However, it did instruct the Executive Secretary to try to work out some arrangement with the Division whereby the physician could be reimbursed for the costs of the drugs and materials used by his nurse—either through direct payment or through a short-term additional award to the recipient who in turn would pay the physician for the drugs and materials.

ETHICAL QUESTION

A communication from a pathologist was read and thoroughly discussed. The letter requested an opinion from the State Medical Association as to whether or not it would be unethical for a pathologist who is an M. D. to perform work for a county coroner who is a doctor of osteopathy. On **motion** duly made, seconded and **carried**, The Council expressed the opinion that it would not be unethical for the pathologist to perform such work, inasmuch as he would not be rendering such services voluntarily but only because it would be a civic duty and meeting a responsibility in assisting a public official in proper administration of the law.

On **motion** duly made, seconded and **carried**, The Council approved a request that the Ohio State Medical Association co-sponsor a course in pulmonary diseases to be offered on Friday and Saturday, September 25 and 26, 1953, at the Ohio State University Medical Center under the auspices of the Ohio State University College of Medicine, the Ohio Tuberculosis and Health Association and the Ohio State Medical Association.

Action was deferred on a request from the Ohio State Nurses' Association that the O. S. M. A. provide its members with a copy of a folder reviewing the provisions of a bill revising the Nurses' Practice Act and to include a provision for the licensing of practical nurses. The Executive Secretary was instructed to advise the Nurses' Association that this matter would be considered the early part of next year when The Council meets to review all measures pending before the Ohio General Assembly.

MISCELLANEOUS

Action on a request from a member that the Association establish a section on physical medicine and rehabilitation was deferred, pending further discussions with the member submitting such a request.

A resolution adopted by the Cleveland and Cincinnati Dermatological Societies, requesting the State Medical Board to revise its rules relating to cosmetic therapy to prohibit treatment of growths and moles by cosmetic therapists, was approved by The Council and the Board requested to take action on this matter at the earliest possible date.

A communication from the American Association of Blood Banks, requesting the O. S. M. A. to adopt a resolution regarding a reorganization of the national blood program was held pending, as it was pointed out that this matter is now under consideration by the Board of Trustees and the Committee on Blood Banks of the American Medical Association.

Dr. C. C. Sherburne, Columbus, one of Ohio's delegates, presented a verbal report on the transactions of the House of Delegates at the recent interim session at Denver, and his report was supplemented by comments by the Executive Secretary and the Assistant Executive Secretary.

The Council was advised that the Association might be asked at a future date to set a policy with respect to a proposed amendment to the Constitution of the United States which would place a limitation on the taxing powers of the Congress. Many members of The Council expressed themselves as believing that this is not a sound and practical way of keeping taxes at a reasonable and equitable level, and on **motion**, duly made, seconded and **carried**, The Council disapproved any such proposal.

The Council reviewed a film "Cheers for Chubby," prepared for the Metropolitan Life Insurance Company and dealing with the subject of overweight and which is to be offered as an educational film to Ohio motion picture theaters in the near future. By official action, The Council approved the film and authorized the President

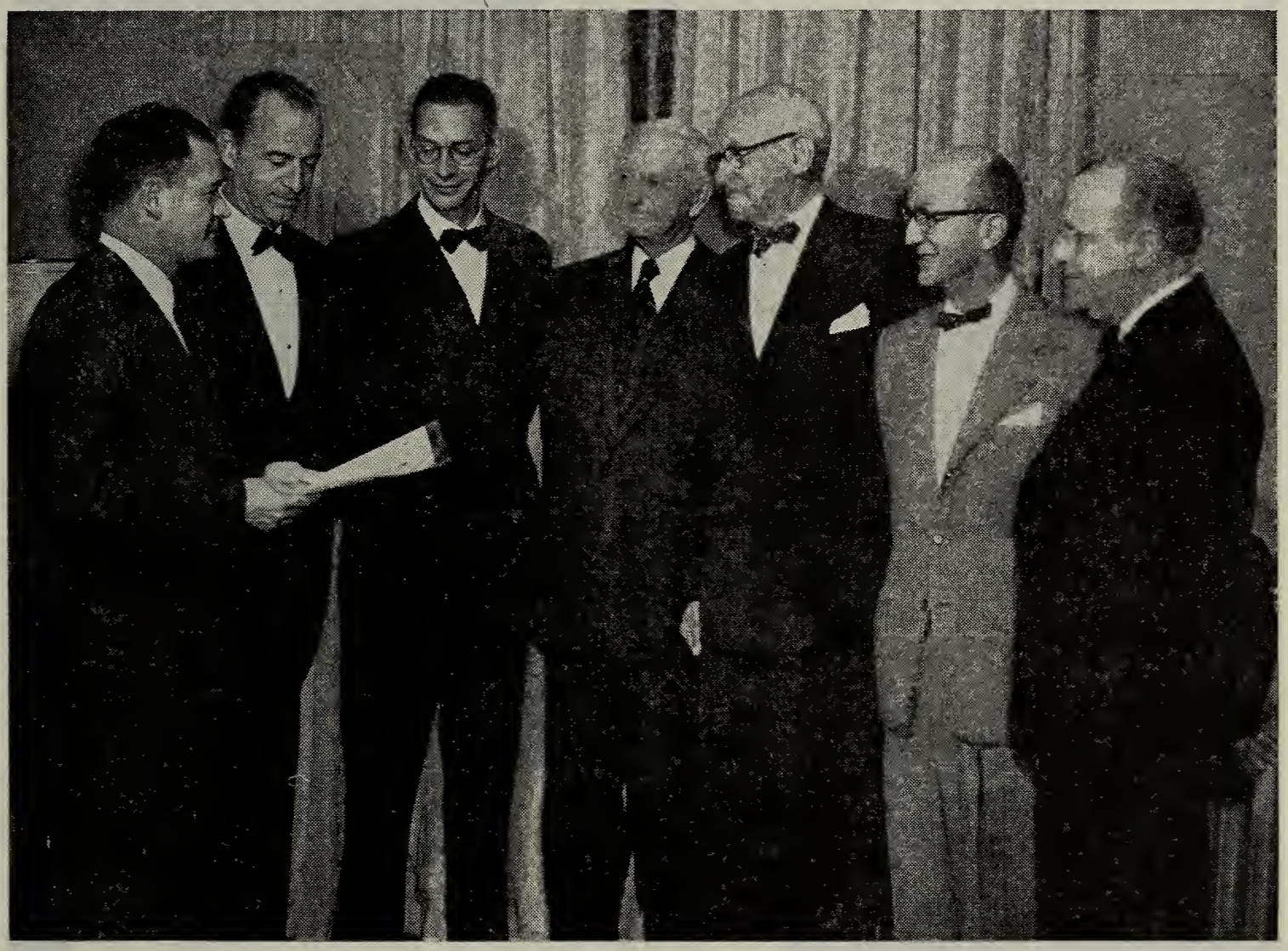
to convey this information to the Metropolitan Life Insurance Company.

The Executive Secretary announced that it had been necessary to secure new dates for the Fall conference at the Granville Inn, Granville, Ohio, because of other activities taking place in Granville on the week-end originally selected. The Council approved the holding of the conference at Granville on the week-end of October 2, 3 and 4, 1953.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

Columbus Academy Honors 50-Year Members . . .



Two father-son teams were present at Columbus Country Club, December 10, when the Columbus Academy of Medicine presented Ohio State Medical Association Certificates of Distinction to eight local physicians who have practiced 50 years. Shown in the photo, left to right, are: Dr. William F. Mitchell, Tenth District Councillor of Ohio State Medical Association; Drs. Gilman D. Kirk, Robert C. Kirk, twin brothers, and their father, Dr. Chester C. Kirk; Dr. William D. Inglis and his son, Dr. Robert M. Inglis; and Dr. Warren G. Harding II, president of the Academy. Also honored, in addition to Dr. Chester C. Kirk and Dr. William D. Inglis, were Drs. Garfield Alcorn, Arthur G. Helmick, Harry Prushing, Albert I. Sherman, Otto M. Hendershot, and John W. Brobst.

New A. M. A. Pamphlet

A new pamphlet—"The AMAzing Story"—prepared by the American Medical Association, gives the general public a brief summary of the ways in which the A. M. A. serves an average American family. This booklet pictorializes the many ways the Association serves Mr. and Mrs. Joe Typical and family. The pamphlet was distributed to all A. M. A. members December 1.

Exhibit Catalog

A new exhibit catalog prepared by the A.M.A.'s Bureau of Exhibits, carries pictures of 25 different health exhibits, with brief descriptions and such installation data as the minimum space and electrical requirements and shipping weights. All of these exhibits are available on a loan basis to medical societies from the Bureau.

Presentations for All Physicians By Specialty Sections Will Highlight 1953 Annual Meeting

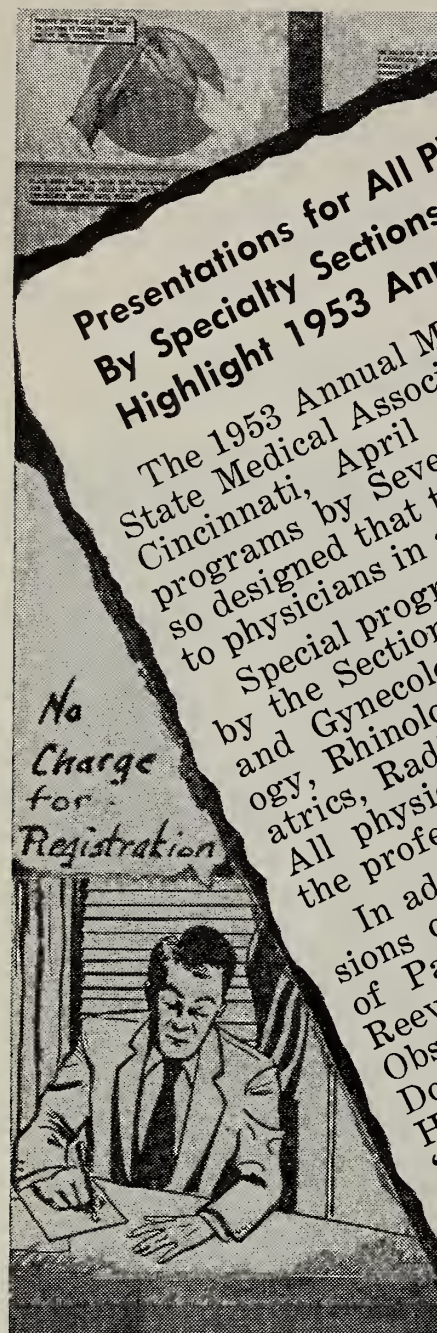
The 1953 Annual Meeting of the Ohio State Medical Association to be held in Cincinnati, April 21-23, will present programs by Seven Specialty Sections, so designed that they will be of interest to physicians in all branches of practice. Special programs are being conducted by the Sections on Urology, Obstetrics and Gynecology, Ophthalmology, Otology, Rhinology and Laryngology, Pediatrics, Radiology and General Practice. All physicians in good standing with the profession are welcome.

In addition, there will be general sessions on "The Anesthetic Management of Patients with Heart Disease," "A Reevaluation of Endocrine Therapy in Obstetrics and Gynecology," "What To Do About Strabismus," "Radiation Hazards in Diagnostic Roentgenology," "Management of the Alcoholic Patient," "Medical Management of Peptic Ulcer," "Surgical Management of Peptic Ulcer," "The Treatment of Coronary Heart Disease," "Surgical Therapy in Portal Hypertension," and others to be announced.

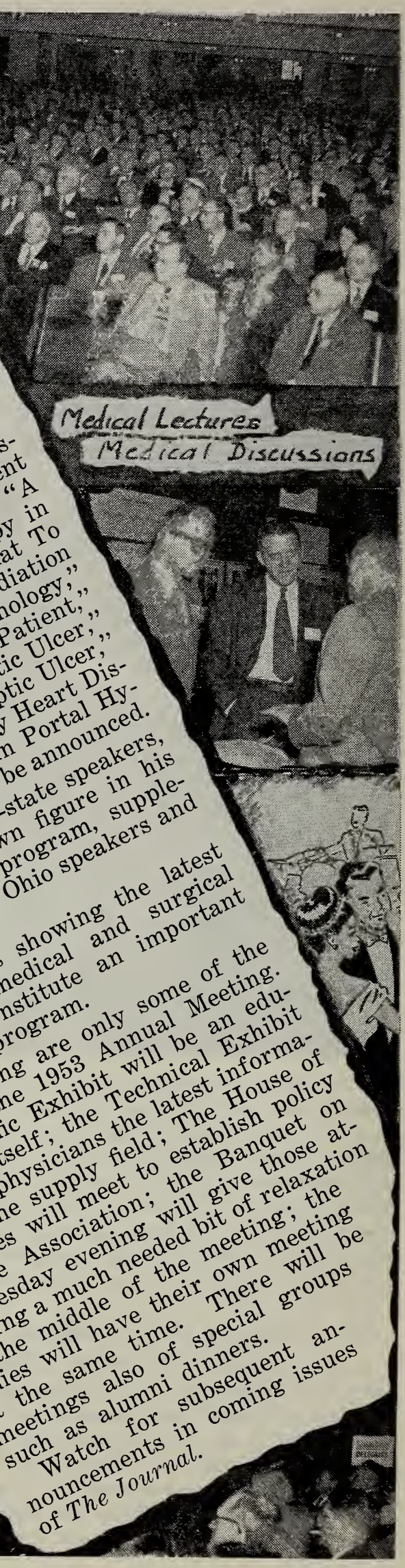
Eleven or more out-of-state speakers, each a nationally known figure in his field, will be on the program, supplementing the array of Ohio speakers and panel discussants.

Moving pictures showing the latest innovations in medical and surgical practice will constitute an important feature of the program.

The foregoing are only some of the features of the 1953 Annual Meeting. The Scientific Exhibit will be an education in itself; the Technical Exhibit will offer physicians the latest information in the supply field; The House of Delegates will meet to establish policy for the Association; the Banquet on Wednesday evening will give those attending a much needed bit of relaxation in the middle of the meeting; the ladies will have their own meeting at the same time. There will be meetings also of special groups such as alumni dinners. Watch for subsequent announcements in coming issues of *The Journal*.







APPLICATION

For Space in the Scientific and Educational Exhibit

1953 Annual Meeting • Ohio State Medical Association

NETHERLAND PLAZA HOTEL CINCINNATI, OHIO APRIL 21-23, 1953

Fill Out and Mail to:

JOHN F. MUELLER, M. D., *Chairman*
Committee on Scientific and Educational Exhibits
Department of Internal Medicine,
Cincinnati General Hospital,
Cincinnati 29, Ohio

---

1. Title of Exhibit: _____

2. Description or nature of exhibit: (attach 200-word description to this blank).

3. Will radiologic viewing boxes be needed? If so, state number and size:
Number of boxes needed_____ Size required_____
(Please indicate if you plan to furnish own view box.)

4. Will you require shelf space? If so, how much? _____

5. How much floor space will you require? _____

6. How much back wall space will you require? _____

7. How much side wall space will you require? _____

8. Other material or equipment required: _____

9. Name of exhibitor: _____

_____ (Street) _____ (City)

10. Name of institution cooperating in exhibit (if desired):

_____

_____

Cost of transporting exhibits to the meeting must be borne by individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.



Mark These Dates—

On Your 1953 Calendar

And Make

Hotel Reservations Now

for the

1953 Annual Meeting

Ohio State Medical Association

Cincinnati, Ohio . . . April 21, 22, 23

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BED
NETHERLAND PLAZA HOTEL	$5.50-12.00	$10.00-12.50	$10.50-15.50
ALMS HOTEL			$8.70-9.70
BROADWAY HOTEL	$3.50	$5.50-6.50	
CINCINNATIAN (Formerly Palace)	$2.50-4.00	$4.00-6.00	$5.00-7.00
FOUNTAIN SQUARE HOTEL	$4.50-6.50	$6.50-9.50	$8.50-9.50
METROPOLE HOTEL	$4.00-8.00	$6.50-8.50	$6.50-10.50
SHERATON-GIBSON HOTEL	$5.00-12.00	$7.50-12.00	$9.00-15.00
SINTON HOTEL	$5.00-12.00	$6.50-11.00	$9.00-11.00
TERRACE PLAZA HOTEL	$9.00-15.00		$12.00-18.00
VERNON MANOR		$4.00-6.00	$5.00-9.00

(Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Cincinnati, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 21, 22, 23, 1953, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Suite

Arriving April..... at..... A. M..... P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

Merger of Health Units . . .

Reasons for Consolidation of Local Departments Presented; Provisions Of Law Setting Up Several Ways for Pooling of Districts Are Reviewed

IN the December, 1952, issue of *The Journal* there appeared an article entitled "Better Local Health Units." It related steps which are being taken to improve the efficiency and financial status of public health activities in Ohio. The official policy and attitude of the Ohio Department of Health on these matters were quoted. The promise was made that additional articles would be published for the enlightment of physicians.

This is the second article. It will review the provisions of Ohio law with regard to the consolidation of local public health units. This is an important point as fewer but stronger public health departments are needed in Ohio in order to bring about over-all improvement in the state's public health program.

Once again, *Ohio's Health*, official publication of the Ohio Department of Health, supplies the necessary data. In a recent issue, that magazine carried the following material on the reasons for consolidation of local public health departments and how consolidation may be accomplished:

QUOTES FROM O. D. H. MAGAZINE

"Many cities and counties have found that by pooling their resources and services they are in a position to achieve their public health objectives. Consolidation of local health units takes form when communities decide to do jointly what they cannot accomplish alone. The principle of consolidation is well established and universally accepted.

"Today in Ohio there are 63 cities and 26 counties which are not offering full-time and complete health services to their people. This represents 1,538,387 persons—19.46 per cent of Ohio's population—who find themselves in the position of needing increased quality and quantity of local public health services.

"A reasonable level of individual and, more particularly, group health for every community may be attained. It is, of course, dependent upon the ability of the individual health districts to provide an adequately supported and efficient health organization. Many health districts are not financially able to support alone adequate public health programs. Ohio law, however, provides methods for consolidation of such local health districts.

CITY-COUNTY COMBINATION

"Sections 1261-20 and 126-21 of the Ohio General Code permit combination of a city health district with a general health district to form one health unit. Here, briefly, is the formal process followed in order to bring about the combination of a city and a general (county) health district.

"The city council must make and adopt a resolution authorizing the mayor of the municipality to enter into a contract with the chairman of the district advisory council of the general health district for the combination of the two districts.

"The district advisory council, made up of village mayors and township trustee chairmen in the general health district, must adopt a resolution authorizing its chairman to enter into a contract with the mayor of the interested municipality for the combination of the districts.

"After adoption of these resolutions by both agencies, the mayor of the city and the chairman of the advisory council must meet and negotiate a contract for public health services. Such a contract would contain the following items:

"1. A stipulated date on which the administration of public health services are to be combined.

"2. Designation of either the original board of health of the city or of the general health district as the administrative body of the combined health district. Generally it is the board of health of the original general health district which is retained. The first vacancy on that board, occurring by resignation, expiration of term, or other reason, is filled by a resident of the municipality, with the appointment coming from the district advisory council with the city mayor as a new member.

"3. Specific assurance that the public health services provided for the municipality shall be as are required of a city health department by the Ohio General Code and the Ohio Sanitary Code, and such other public health services as are authorized by law and can be furnished within the money appropriated to the board of health.

"4. Stipulations as to the proportion of funds to be provided by the city and by the general health district in their new union.

"5. An escape clause so that either party may terminate their consolidation provided that a six-month notice of intent is given.

"When such a contract has been signed, a copy must be filed with the Ohio Department of Health. This keeps the state agency informed of action on the local level in developing a picture of the state's over-all health organization and conditions.

"Health rules and regulations of the original general health district become effective in the city as well when the contract goes into effect. Regulations adopted by the city before consolidation may, in addition, be continued by action

of the board of health of the consolidated district and enforced separately in that portion of the health district.

CITIES MAY COMBINE

"A city may enter into a contract for public health services with the council or managing officer or officers of another city. Such proposal must be made by the city seeking health services and must be approved by the majority of members of its city council. Such a contract would provide agreement on:

"(a) the amount and terms of payment by the petitioning city for health services;

"(b) the amount and character of health services to be given by the one city health district to the other; and

"(c) the date on which health services would begin and end under the contract.

"Such a contract cannot become effective, however, until the O. D. H. has determined that the city health department contracting to provide health services to another is organized and equipped to do so. With O. D. H. approval and effectiveness of the contract, the board of health of the city seeking service is disbanded and the health department of the city providing health services has within the city receiving such services all the powers and must perform all the duties previously or thereafter granted to or required of a city health district.

CO-OPERATIVE AGREEMENT

"Another method used rather widely in Ohio to consolidate health districts—particularly two or more county districts—is one known as a system of co-operation. Under this system the following elements are present.

"1. The separate boards of health of the two or more health districts remain active and retain all of their inherent duties and responsibilities.

"2. Separate budgets are prepared for the co-operating health districts and are processed as in the past. There is no co-mingling of funds of the districts.

"3. All regulations and orders of each board of health remain in effect and continue to be enforced in the respective health district which had adopted them.

"4. The staffs of the two or more health districts are retained, but all are subject to the administrative guidance, direction, and medical consultative services of the full-time physician who is shared as the health commissioner of the co-operating districts.

"5. In addition to sharing the health commissioner, certain supervisory personnel such as a chief sanitarian or chief nurse may also be jointly hired if it is considered advisable. Each employee so hired would have responsibilities distributed between the health districts.

"6. The personnel of the two or more co-operating health departments may be housed separately although joint housing is preferred in order to promote better administrative efficiency.

"7. The two or more boards of health agree to meet together at least twice a year for a joint review of the activities of the health units and for consideration of policies needed for regulations and other public health matters which would have a beneficial effect upon their operation.

"Under any of these methods of consolidation there are no disadvantages. A community must not be misled, however, into thinking that the mere act of consolidation is the panacea to its public health problems. It is the job of the community to pay its way, to provide adequate salaries to attract and retain professionally qualified personnel, to give understanding and co-operation to those persons in the pursuit of their duties, to require of those persons a high standard of performance.

"As the population has increased, so, directly, has the problem of the public's health; there are more people; they live for a longer time. Today's mode of living, traveling, and working has created situations never faced—even dreamed of—by public health of 50 years ago.

"So, as the job is bigger, support of the job must be greater. Consolidation of individual health departments—pooling resources for the reward of better service—is one of the most feasible means of support."

Cardiac Patient in Industry To Be Theme of Cleveland Meeting

A state-wide program to discuss the place of the cardiac patient in industry will be held at the Hotel Hollenden in Cleveland on Wednesday, January 28, under the sponsorship of the Ohio State Heart Association and its affiliates. This will be the first conference of this type to be held in Ohio and one of the first in the nation.

Topics to be discussed will include, "Existing Programs for the Selective Placement of the Cardiac Patient in Competitive Industry," "Management and the Cardiac Employee," "Organized Labor Views Heart Disease in Relation to Employment," "Working With Your Heart," and "Practical Aspects in the Employment of the Cardiac Patient."

Dr. Edward M. Kline, medical consultant, Lamp Division, General Electric Company, of Cleveland, is chairman of the planning committee.

Affiliates of the Ohio State Heart Association are the Cleveland Area Heart Society which will be the host; Akron District Heart Association; Central Ohio Heart Association; Heart Association of Greater Cincinnati; Northwestern Ohio Heart Association and Youngstown District Heart Association. Reservations may be made with headquarters office of the Ohio State Heart Association, 55 E. State St., Columbus 15, or with any of the affiliate organizations.

Doctors' Draft Law . . .

A. M. A. House of Delegates Defers Action on Proposal for Re-enactment Pending Further Study for Need; V. A. Problems Also Given Consideration

MOST of the fireworks which took place at the mid-year meeting of the House of Delegates of the American Medical Association, December 2-4, in Denver, resulted from consideration of the following vital issues:

1. Public Law 779, the Doctors' Draft Act;

2. Curtailment of medical and hospital services by the Veterans Administration for non-service-connected cases.

The Doctors' Draft Act issue was thrown into the hopper in the form of a special report of the Board of Trustees which recommended that the A. M. A. withhold any action on the proposed extension of Public Law 779 beyond its present expiration date until such time as more specific data and satisfactory answers to a number of vital questions are available and that the Board be given authority to take appropriate action when it is deemed advisable.

DOCTORS' DRAFT ACT

Public Law 779 is due to expire on June 30, 1953. There has been considerable controversy as to whether it should be reenacted.

Representatives of the armed services have contended that continuation of the Doctors' Draft Act is necessary in order to provide the services with an adequate number of medical officers to replace medical officers completing their tour of active duty or to meet additional needs resulting from a possible increase in the size of all, or any one, of the armed services.

On the other hand, questions have been raised as to the use of medical officers for the care of the dependents of military personnel; whether or not medical officers are being used economically and efficiently; and whether the draft is necessary to meet the basic needs of the medical branches of the armed services.

Proposals requesting the A. M. A. to endorse renewal of Public Law 779 and proposals requesting the A. M. A. to oppose its reenactment were presented to the House of Delegates for action.

DEFINITE ACTION DEFERRED

Final action of the House of Delegates, through adoption of a report of the Reference Committee on Medical Military Affairs of which Dr. George A. Woodhouse, Pleasant Hill, an Ohio delegate, was a member, contained the following pronouncements and recommendations:

1. Recognized the responsibility of the American Medical Association to support essential medical care to the uniformed armed services.

2. **Recommended that the House of Delegates take no definite position at this time on the reenactment of Public Law 779 but instructed the Board of Trustees and the Council on Emergency Medical Service to study future military developments and the need for Legislation and to support necessary legislation, if such action is deemed advisable prior to the next meeting of the House of Delegates next June.**

3. Mandated the Board and the Council on Emergency Medical Service to give consideration to the following points in its study of this problem:

A. Developments, both national and international, which might affect the quantitative requirement of the armed forces for medical officers.

B. That the Board in determining the need for reenactment of the Doctors' Draft Act in some form, insist that the following principles and policies be given due consideration in proposed legislation, so far as consistent with the public interest:

PRINCIPLES LAID DOWN

(1) Realistic revision of physical requirements for medical officers to the end that physicians with physical defects be utilized with appropriate assignment.

(2) Development of more effective recruitment methods for career personnel in military medicine and support of the Armed Forces Medical Policy Council's efforts in this direction.

(3) Greater use of civilian doctors of medicine and civilian hospital facilities, whenever and wherever feasible, in the care of both military and non-military personnel and dependents of military personnel.

(4) Most economical and efficient use of the medical manpower pool since the total number of doctors of medicine avail-

able to the various governmental agencies and for the general health needs of the nation is irreplaceable and of relatively fixed proportions.

(5) That conditions of service in the several governmental agencies are sufficiently uniform to avoid undue competition for medical personnel.

(6) Consideration of an equitable point system in the induction of doctors of medicine into the medical departments of the armed services.

REGARDING PRIORITY NO. 3

4. **Requested the President of the United States to defer any call-up of Priority No. 3 physicians under Public Law 779 until the Selective Service System and the Department of Defense have completed the processing of all physicians in Priority No. 1 and Priority No. 2 and have called to active military service all physicians in these groups except those very occasional individuals whose further deferment is essential to the nation's health, safety and interest.**

5. Reiterated A. M. A. approval of the $100 per month special pay for physicians in the armed services because promotions cannot be given in the services, with few exceptions, under the present tables of organization.

6. Commended the National Advisory Committee to the Selective Service System and the respective state and local committees for the work they have done.

7. Suggested that the National Advisory Committee to the Selective Service System call a meeting of state chairmen prior to the time that they may make any final recommendation to the Congress regarding the reenactment of Public Law 779, to obtain their thinking on the present law and the need for its reenactment.

CARE OF VETERANS

Another vital question considered by the A. M. A. House of Delegates and which produced heated debate was that relating to the Veterans Administration medical and hospitalization program, especially that part of the program which provides services for veterans with non-service-connected disabilities.

The matter was brought to the floor of the House of Delegates in the form of a lengthy report by a six-man A. M. A. committee which had been studying the problem for many months.

This report recommended that Public Law 312 be amended to limit medical and hospital benefits of the Veterans Administration to (1) veterans with disabilities incurred in or aggravated by military service and (2) veterans suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin who are unable to defray the expenses of necessary medical and hospital care.

ADVOCATE LOCAL CARE

With regard to medical care and hospitalization for the remaining groups of veterans with non-service-connected disabilities, i.e., acute conditions or conditions which do not require long hospitalization, the special committee recommended that Veterans Administration benefits "be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

Explaining its second recommendation, the special committee in its report stated:

COMMITTEE EXPLAINS

"The recommendation of the Committee with respect to the treatment of veterans with tuberculosis and neuropsychiatric disorders of non-service origin in Federal hospitals is believed necessary at this time because of the inadequacy of local facilities designed to provide treatment for all such cases. It is the feeling of the Committee, however, that the entire question of whether the care of these patients is a local or a Federal responsibility must be reanalyzed by the Congress. The rapidly expanding veteran population and the need for facilities for the remainder of our citizens afflicted with these diseases suggests that community facilities must be developed under state or local administration for the benefit of all. Preferential treatment for veterans with these non-service-connected disabilities cannot be continued indefinitely, in view of its detrimental effect on the health and the economy of the entire nation."

Prolonged hearings on the issue were held by the Reference Committee on Insurance and Medical Service. Many individual physicians testified as well as representatives of the Veterans Administration, American Legion and other groups and organizations.

VIEWS OF LEGION

The debate revolved around the question as to whether or not the A. M. A. should recommend at this time revision of the law to limit care of non-service-connected cases to veterans with tuberculosis and neuropsychiatric disorders who are unable to defray the costs of necessary medical and hospital care.

The position of those opposing the amending of the law at this time is summed up in the following statement made by representatives of the American Legion:

"The position of the American Legion is that if these categories of non-service-connected cases (tuberculosis and neuropsychiatric) are accepted as under the present law, that we the American Legion stand willing and ready to join with the

American Medical Association, American Hospital Association, American Dental Association and all others to prevent the non-service cases which we might term 'chiselers' from ever receiving treatment by the Veterans Administration. The presence of such an individual who can afford to pay for his private medical care in a Veterans Administration bed means to us that he is depriving a worthy and qualified veteran from receiving the care the Congress and the people of this country intend for him to have. Believing as we do the above principles, we think that the present law, P. L. 312, should stand without the dangerous procedure of tampering with it in the Congress. By the same token, we believe that the enforcement of the present law by administrative means should be reconsidered with every American demanding its fair enforcement. The Legion has already helped accomplish some administrative changes."

FINAL ACTION OF HOUSE

After much debate, the House of Delegates adopted the report of the reference committee which supported much of the special committee's work but recommended that more study be given to the complex problem of non-service-connected cases and whether Public Law 312 should be amended.

The following two paragraphs of the reference committee's report summarize the major recommendations of that committee and the final action of the House of Delegates:

"The reference committee believes that the recommendation of the special committee '. . . that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs' cannot be accomplished without the cooperation of Congress, veterans organizations and the medical profession.

"The reference committee, after conducting exhaustive hearings, is of the opinion that the only honorable, equitable and reasonable way to approach the problem is to recommend to the House of Delegates that the American Medical Association, the veterans organizations, the American Dental Association, the American Hospital Association, and representatives of the Department of Defense and the Veterans Administration sit down and try to reach reasonable conclusions for appropriate action from agreed upon data rather than take any precipitate action now."

The final action also carried a recommendation that conferences be held in each state for the purpose of discussing this question, such conferences to be participated in by representatives of the state medical, hospital and dental societies and of veterans service organizations, such as the American Legion, Disabled Veterans Association, Amvets, etc.

Farm Bureau Adopts Resolutions On Rural Health Improvement

The 261 official delegates to the 34th Annual Meeting of the Ohio Farm Bureau Federation, November 24-26, in Columbus, adopted the following Rural Health platform for 1953:

"We urge each County Farm Bureau:

1. To cooperate with county health agencies in securing adequate funds to operate efficiently a county health department;

2. To support legislation which would permit counties to vote once every five years for an annual half-mill levy for health purposes instead of voting every year as now required by law (The Wheeler Bill);

3. To study health conditions, including problems, facilities, ways and means of improving local health, and the creation of larger health districts."

Delegates recommended that the General Assembly of Ohio appropriate sufficient funds to enable the Ohio Department of Health to carry on the activities required of it "without depending on Federal grant-in-aid funds to pay for essential state services."

Legislation which will provide for the compulsory vaccination of all dogs "as an effective means of controlling rabies" was urged; annual health examinations including chest x-rays as a requirement for all school personnel, handlers of food in public eating places and all those who assist in the processing of food were requested; and delegates "insisted" that the inspection and licensing of public eating places be under the supervision of the State Health Department rather than under the State Fire Marshal."

"Due to the complex duties of the State Department of Welfare," it was recommended that it be organized into two executive departments, namely: 1. Department of Mental Health and Institutions, and 2. Department of Social Welfare.

"You and Your Medical Care"

The story of how local medical societies bring medical care and medical services to more and more American people is the subject of a new exhibit which is nearing completion by the A. M. A.'s Bureau of Exhibits. "You and Your Medical Care" exhibit features emergency call services, voluntary health insurance, early detection and prevention of such diseases as cancer and tuberculosis, community health councils, grievance committees and sources of health education information.

Cleveland Doctors Launch TV Series . . .



Discussing the script for Cleveland's new Sunday afternoon television program, "Prescription for Living," are, left to right, Dr. Robert M. Stecher, president, the Cleveland Health Museum; Warren Guthrie, moderator for the program, and Dr. Charles L. Hudson, president of the Academy of Medicine of Cleveland, and Councilor of the Fifth District of the Ohio State Medical Association. The Health Museum and the Cleveland Academy will jointly present the programs under sponsorship of the Standard Oil Company of Ohio.

The programs will be televised each Sunday beginning at 4 p. m. on an all-Ohio hook-up—the first on January 4. Originating in Station WXEL, Cleveland, it will be carried on Stations WTVN, Columbus; WHIO, Dayton; WSPD, Toledo; and WCPO, Cincinnati.

A. M. A. Committee on Mental Health Is Established

The Board of Trustees of the A. M. A. recently approved the appointment of Dr. Richard J. Plunkett as full-time secretary of the newly established standing Committee on Mental Health of the American Medical Association. The new committee is composed of Dr. Leo H. Bartemeier, Detroit, as chairman, and six other outstanding specialists in the general fields of psychiatry and neurology.

Dr. Plunkett, who has been a member of the A. M. A. editorial staff for the past five years, was graduated from Tufts Medical School, the Harvard School of Public Health, and is certified by the American Board of Public Health and Preventive Medicine.

The committee was formed primarily to consider the many problems which exist today in psychiatry and mental health; problems which face physicians, medical educators and the general public alike.

Eaton—Dr. George W. Flory, was elected Preble County coroner for his fourth term. He is 90 years old.

Dr. Russel G. Means, Columbus, has been appointed to the Board of the National Budget Committee, the quota committee sponsored by the Community Chests and Councils of America, Inc., and the National Welfare Assembly, Inc. The committee also serves as Budget Committee of the United Defense Fund, Inc. Dr. Means is the only member of the medical profession on this board of one hundred persons.

Medical Board Examinations . . .

Sixty-four Applicants To Practice Medicine and Surgery in Ohio Take State Board Examinations; List of Questions Asked M. D.'s Is Given

LICENSES to practice medicine and surgery in Ohio were sought by 64 graduates of medical schools at the examinations of the State Medical Board held in Columbus, December 1-3.

Twenty-three persons took the examinations to practice osteopathic medicine and surgery. In the limited practitioner field, examinations were taken by 59 chiropractors, 26 mechanotherapists, 9 chiropidists, 19 masseurs and 6 cosmetic therapists.

Results of the examinations will be announced following a meeting of the Board on January 13.

Following are the written examination questions asked those applying for licenses to practice medicine and surgery:

ANATOMY

1. Discuss the origin, course and distribution of the external carotid artery.
2. Describe the capsule of the knee joint.
3. In complete hemiplegia what nerve centers are affected and in what manner? Why is the leg first to show improvement?
4. Discuss the cranial parasympathetic outflow.
5. What artery is sometimes in danger of being damaged in operating a strangulated inguinal hernia?
6. Describe the mediastinum and its contents.
7. Name and give the source of the various tributaries of the portal vein.
8. Describe the embryologic development of the pituitary gland. What are its various functions?
9. Describe the trigonum vesicae.
10. Describe the left atrioventricular valve and its support.

PHYSIOLOGY

1. Discuss the relations of blood plasma, tissue fluid, and lymph to one another.
2. Discuss the physiology of the adrenal cortex.
3. Discuss the relation of the cerebral cortex to the tone of skeletal muscle.
4. Discuss the physiological mechanisms responsible for the increased pulmonary ventilation of muscular exercise.
5. What factors are responsible for converting the flow of blood from a pulsatile one in the arteries to a steady one in the capillaries?
6. Discuss the absorption of water and water-soluble substances from the different divisions of the gastrointestinal tract.
7. Discuss the factors which determine the flow of blood through the brain.
8. What factors determine the oxygen content of blood in the right auricle of the heart?
9. Account for the fact that the body temperature may not rise when the temperature of the surrounding air is higher than that of the body.
10. Describe and explain the effects of section of the vagi in the cervical region upon breathing.

BACTERIOLOGY

1. For each of the following, name one disease and the fungus involved: (a) A mycosis in which internal organs are chiefly affected. (b) A mycosis in which the skin and subcutaneous tissues are affected. (c) A superficial dermatomycosis.
2. List the means by which brucellosis may be transmitted.
3. Name three infectious diseases that commonly may be transmitted by blood transfusion.
4. List four organisms commonly found in the "normal flora" of the body, or in the soil, that may cause disease in man, and in each instance state the name of the disease.
5. List the essential components of a septic tank installation.

DIAGNOSIS

1. A patient has a metastatic tumor of the spine. Enumerate four types of primary tumors that are especially likely to metastasize to the vertebrae.
2. Differentiate between hyperthyroidism and an anxiety state with cardiac manifestations.
3. Discuss the diagnosis of co-arctation of the aorta.
4. Give the diagnosis of perinephritic abscess.
5. Give the following information regarding trichinosis: (a) etiological agent; (b) mode of transmission; (c) diagnostically important clinical and laboratory features; (d) prognosis.
6. A male, fifty-five years of age, is brought to the emergency ward in coma. List the clinical and laboratory observations that would aid you in ascertaining the cause of the patient's comatose state.
7. What are the distinguishing features between a psychoneurosis and a psychosis?
8. Discuss the differential diagnosis of osteoporosis of the menopause, osteomalacia, and osteitis fibrosa cystica in terms of (a) results of biochemical studies; (b) X-ray examination.
9. Describe the bacteriological diagnosis and the clinical course of pneumonia caused by Friedlander's bacillus.
10. A male sixty years old has severe pain in the lumbar region that has been persistent for several months. Discuss the differential diagnosis.

CHEMISTRY

1. Name the positive Electrolytes; the negative Electrolytes.
2. Discuss factors involved in the normal interchange of fluids between the vascular compartment and the tissue space.
3. Distinguish between endogenous and exogenous metabolism.
4. Discuss the formation of bile pigments.
5. What is the origin, chemical state and function of creatin in muscle.

MATERIA MEDICA AND THERAPEUTICS

1. Define and give example of a direct and indirect effect of a drug.
2. In a patient suffering from congestive heart failure what effect has digitalis upon the ventricular diastolic pressure and the peripheral venous pressure and blood volume?
3. Name five drugs you most frequently use and give dosage of each.
4. (a) Give the mechanism of action of sulfonamide compounds. (b) Give toxic manifestations of these drugs.
5. Give five general principles that are widely applicable to a case of poisoning.
6. Outline care of a patient with a febrile illness.
7. Give the treatment of acquired hemolytic anemia.
8. Give the treatment of chronic pyelonephritis.
9. Outline treatment of latent syphilis.
10. Name two drugs and give dosage that act peripherally on the autonomic system.

PRACTICE

1. Discuss the control of the medical and the psychogenic factors that delay the healing of a duodenal ulcer.
2. A patient with chronic nephritis has a blood pressure of 170/100, an elevated NPN and creatinine, serum albumin 3.0, serum globulin 3.0, albumin 2 plus in urine, a urinary specific gravity in random specimen of 1.010 to 1.014, a few flame-shaped hemorrhages in the eyegrounds but no widespread edema. He is able to eat an ordinary diet without nausea or vomiting. Discuss the dietary treatment.
3. A patient has an encapsulated left interlobar empyema. Describe the treatment.
4. Discuss the use of curare in (a) shock therapy; (b) anaesthesia; (c) multiple sclerosis. What would be the effect of similar doses administered to a patient with myasthenia gravis?
5. Give the management of carcinoma of the stomach involving the cardia and the lower esophagus.
6. Give the etiology and signs of erythema nodosum.
7. Give the etiology of primary acute adrenal cortical insufficiency.
8. Enumerate the causes of dysphagia.
9. Give the etiology manifestations and course of relapsing fever.
10. Give the etiology and manifestations of tetanus.

PATHOLOGY

1. In outline form describe the gross appearance of tuberculous pericarditis.
2. List the basic pathological processes in the disease erythroblastosis foetalis.
3. List the anatomic changes resulting from a deficiency of Vitamin A.

MEMBERSHIP DUES FOR THE OHIO STATE MEDICAL ASSOCIATION, INCLUDING SUBSCRIPTION TO THE OHIO STATE MEDICAL JOURNAL, ARE NOW OUTSTANDING UNLESS PREVIOUSLY PAID.

Physicians who have not already done so, should immediately pay 1953 membership dues. Dues for the Ohio State Medical Association (which include subscription to *The Journal*) are $20. This amount should be added to county medical society dues and paid **to the secretary-treasurer of your county society.** Membership dues for the American Medical Association (including subscription to *The Journal of the A. M. A.* or another publication of choice) are $25. Physicians who wish membership in the A. M. A. should add this sum to the amount paid the county society secretary-treasurer.

Memberships and membership subscriptions are on a calendar year basis.

4. In outline form give the microscopic appearance of the liver in a rapidly fatal case of epidemic hepatitis.
5. List the causes of hypoglycemia.
6. Outline the pathogenesis of abscess of the lung.
7. List the factors that lead to the formation of transudates in the serous cavities.
8. List the principal gross and microscopic changes in chronic malaria.
9. Outline the pathogenesis of subdural hematoma.
10. List the morphological changes that occur in a cell injured by x-irridation.

OBSTETRICS AND GYNECOLOGY

1. To what portion of the uterine cavity is the placenta usually attached? Describe the process by which the placental site is determined.
2. Describe the most common cells found in a direct smear (properly fixed and stained) from a normal cervix. What changes in these cells would make you suspect the presence of a neoplasm?
3. Define the condition known as a rectocele. Discuss its causation and the possibility of the prevention of such lesions.
4. Discuss the significance of fibro-myomata discovered for the first time in a woman already about eight weeks pregnant.
5. What factors should be investigated in a woman who, after two years of effort, fails to become pregnant?
6. Describe the management of the third stage of labor. What are the chief dangers in this period?
7. Discuss the importance of flexion of the fetal head in the mechanism of normal labor.
8. Why is pyelonephritis frequent during pregnancy? Outline the management of this complication.
9. & 10. **True or False:**
   (a) Endometriosis is produced when an ova is fertilized in the Fallopian tube.
   (b) A contracted pelvis is an indication for the use of anterior pituitary extract in labor.
   (c) A cervix lacerated during hospital delivery should be packed.
   (d) The most common cause of a vaginal discharge is a neisserian infection.
   (e) The most common pathological tumor in the female pelvis is a fibromyoma.
   (f) Emesis Gravidarum frequently causes acetonuria or ketosis.
   (g) Caput ballotable refers to a head firmly engaged in the pelvic inlet.
   (b) A Couvelaire uterus may result from a prolonged or neglected abruptio placentae.
   (i) Mentum posterior positions rarely deliver spontaneously.
   (j) The Schultze mechanism refers to passage of the head thru the birth canal.

SURGERY

1. Discuss the surgical risk involved in cases of cardiovascular disease.
2. Discuss the management of fractures of the spine at the level of the tenth thoracic vertebra with and without involvement of the spinal cord.
3. Give the indications for and principles underlying the surgical treatment of varicose veins of the lower extremities.
4. Give the common causes of ischiorectal abscess. Discuss its treatment, possible sequelae and their treatment (omit details of operative technique).
5. Give the causes, symptoms, and treatment of stricture of the male urethra.
6. Discuss the significance of blood when (a) coughed up; (b) vomited; (c) passed by rectum.
7. When is operative treatment indicated in the management of fractures of the skull?
8. Give the causes and differential diagnosis of chronic enlargement of the lymph nodes of the neck.
9. Discuss the general and local factors that influence the primary healing of wounds.
10. Discuss the symptoms, differential diagnosis, and indicate the treatment of cholelithiasis.

SPECIALITIES

1. A woman, age 31, has been in an auto accident and her ribs and pelvis have multiple fractures. What are the urological problems that may arise and how would you handle them?
2. Discuss the etiology, appearance and treatment of (A) psoriasis; (b) neurodermatitis.
3. How can you differentiate between an allergic and infectious rhinitis?
4. Describe the treatment for the different stages of syphilis.
5. **True or False:**
   (a) Conjunctival injection is not influenced by adrenalin.
   (b) In primary glaucoma, atropine is indicated.
   (c) A myotic causes stimulation of the iris.
   (d) A ciliary sphinctor is pericorneal.
   (e) A chalazion is a meibomian cyst.

PREVENTIVE MEDICINE AND HYGIENE

1. List the essential features of an adequate pre-natal program. What are the principal causes of still-birth? What are the principal causes of death of the newborn infant (under three months)?
2. Discuss the responsibility of the physician in control of: (a) diphtheria; (b) Tetanus; (c) syphilis.
3. What is the public health importance of rat control?
4. What is the mode of transmission of: (a) psitticosis; (b) bubonic plague; (c) undulant fever; (d) trichinosis.
5. What methods may be used for emergency purification of water in a community in which the regular purification of water is interrupted or does not exist?

'52 "Apparatus Accepted" Available

The 1952 edition of "Apparatus Accepted," a publication of the A. M. A.'s Council on Physical Medicine and Rehabilitation, is available for distribution. The 60-page booklet includes a complete listing of diagnostic and therapeutic devices which have been accepted by the Council. Among other things, the booklet lists such items as audiometers and hearing aids, electrocardiographs, oxygen therapy apparatus, incubators, inhalers and resuscitators, and metabolism testing equipment. Copies may be secured on request through the Council.



Normal peristaltic action results from activity of the muscle layers as they are gently distended by bulk within the intestine; mucosal irritants cause overactivity of the muscle layers resulting in hyperperistalsis or spasm.

Corrective Action of Metamucil® in Abnormal Physiology of Constipation

Abnormally prolonged colonic retention, whether in a spastic or an atonic colon, demands the greatest care to assure correction.

The mucosa does not require stimulating; hence, stimulating cathartics, "roughage" and other physical and chemical irritating measures, are today often considered irrational.

On the other hand, the muscularis does require a stimulus to initiate peristalsis. This physiologic stimulus is the mechanism by which bland distention of the colon establishes a reflex, with the muscularis at the terminus of the reflex arc.

Metamucil literally reeducates the sluggish and also the spastic colon. Taken with adequate amounts of water, Metamucil forms a smooth, hydrophilic colloid. As this colloidal mass passes through the large intestine, it exerts a gentle, distending pressure within the lumen, thus initiating the peristaltic reflex necessary for evacuation.

A program of Metamucil therapy helps to restore proper tone to the intestinal musculature, thereby establishing proper bowel habits.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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Research in the Service of Medicine

Last 50 Years . . .

This Period Has Been Man's Greatest Half-Century Because of Great Progress Made in Medicine and Public Health, Statisticians Claim

THE last 50 years has been man's greatest half-century. Medical progress, aided by better food, housing and sanitation, has produced an unequaled rate of social progress, in the opinions of Frank G. Dickinson, Ph. D., Chicago, and Everett L. Welker, Ph. D., Washington. Dr. Dickinson is director of the Bureau of Medical Economic Research of the American Medical Association. Dr. Welker formerly was the bureau's associate in mathematics.

The decline in the general mortality rate, from 17.2 deaths per 1,000 population in 1900 to only 9.6 in 1950 understates the health progress of the last half-century, they said. While the population has doubled, the number of persons over 65 years of age has quadrupled in this period, and a significant gain in life expectancy, even in late middle age, has resulted from the mortality rate reduction. Life expectancy at birth in 1900 was estimated at 47.3 years; in 1949, it was 67.6 years.

CAUSES OF DEATH SHIFT

Drs. Dickinson and Welker disclosed that the leading causes of death have changed radically during the last half-century. In 1900, the seven leading causes resulted in about one-half of all deaths, while in 1949, the seven leading causes resulted in more than three-fourths of all deaths. In 1900, pneumonia caused 12.9 per cent of all deaths, tuberculosis 10.4 per cent, heart diseases 8.5 per cent, cerebrovascular 6.2 per cent, nephritis 4.7 per cent, accidents 4.1 per cent, and cancer 3.6 per cent.

In 1949, heart diseases caused 32.6 per cent of all deaths, cancer 13.6 per cent, cerebrovascular 9.1 per cent, accidents 6.8 per cent, nephritis 5.4 per cent, pneumonia 3.9 per cent, and tuberculosis 3.0 per cent.

The percentage increases in some of the causes of death undoubtedly are the result of improved diagnosis, according to Drs. Dickinson and Welker. Death certification has improved and physicians are using fewer ill-defined causes now than they did in 1900. Other factors, including medical progress making it possible for persons to live with certain diseases, are also involved.

CHANGE IN MEDICAL PRACTICE

This changing pattern of deaths may have had some effect on the practice of medicine, they pointed out. In 1900, the doctor attending a patient in his final illness might have been fighting any one of a number of maladies. In 1948, in one case in three the physician was dealing with heart disease, and in almost one-half of the cases with either heart disease or cancer. This probably encouraged specialization by physicians in the treatment of these diseases, they stated.

Infant and maternal mortality have served traditionally as indexes of the general health situation, according to Drs. Dickinson and Welker. The maternal mortality rate has dropped to such a startling low—0.8 per 1,000 live births in 1951—that they stated such problems now have become local in nature rather than national, and suggested the discontinuation of such records by the National Office of Vital Statistics. The decrease in infant mortality rates, to 28.6 per 1,000 live births in 1951, also suggests a change in the keeping of such records. They said that such mortality rates should be limited to the first month of life instead of the first year, as is now the case, because about two-thirds of the infant deaths occur during the first month.

PROGRESS IN HEALTH PROGRAMS

"Major mortality gains have resulted from preventive medicine and quick cures," Drs. Dickinson and Welker stated. "Preventive medicine has been successful in eliminating the spread of disease. Medical research has developed many effective methods of immunization and disease prevention; these have been widely used by public health agencies and sanitary engineers under the capable guidance and direction of the medical profession, as well as by the general practitioner. All of these measures have added to the longevity of the American people.

"We started the 20th century with many health disadvantages. The record of accomplishment provides the basic reason why physicians and other enlightened citizens should hold fast against any and all schemes to destroy our system of medical care under which this astounding record was made."

Drs. Dickinson and Welker have prepared a pamphlet describing the mortality trends in the United States during the period from 1900 to 1949, a summary of which appeared in the October 4 *Journal of the American Medical Association.*

Dr. E. K. Yantes, Wilmington, was guest of the Oregon State Medical Society in Salem, where he gave an address on the "Clinton County Health Survey" on December 5

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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

LEGISLATURE OPENS JAN. 5; KEEP YOUR POWDER DRY

Better clear the decks for another busy and hectic session of the Ohio General Assembly. It will open on Monday, January 5. It will close —your guess is as good as ours.

It is anticipated that the number of bills with a medical-health-welfare angle which will be introduced will total between 50 and 60—maybe more.

These will include measures relating to financing of public health activities, inspection of restaurants by public health authorities instead of by the State Fire Marshal, establishment of a separate department of mental health, licensing of practical nurses, enactment of a uniform food, drug and cosmetic act, licensing of hospitals, Workmen's Compensation, various and sundry welfare and public assistance programs, separate boards for examination and licensing of chiropractors and naturopaths and extension of their limited privileges, and many other subjects of interest to the medical profession.

All such bills will be followed closely by representatives of the Ohio State Medical Association. All will be carefully analyzed by The Council and policies regarding them established. Bulletins will be issued at least weekly to the officers and the legislative chairman of each County Medical Society for their information. They will be expected to keep members advised about pending legislation. Moreover, they will be expected to see that members of the General Assembly are acquainted with the views and attitude of their physician constituents on all bills.

To repeat what has been said many, many times in these columns and elsewhere: Votes are made "back home." Legislators will look to their physician constituents for help and guidance on legislative proposals. How they vote will depend to a large extent on how active the physicians of each county are on legislative matters and how well such physicians get across to their legislators the viewpoints of the medical profession.

Working with the State Legislature is not a one-man, a two-man or a one-committee job. It's a job which involves all of the 7800 members of the Association. Unless they are ready and willing to do an educational job with members of the General Assembly in their home communities, they should not be surprised if the results are not to their liking.

AD FUSS IS MUCH ADO ABOUT NOTHING

The *Atlantic Monthly* and Dr. James Howard Means are in a dither because *The Journal of the A. M. A.* refused to publish an advertisement, plugging an issue of that magazine which carried an article by Dr. Means. The *A. M.* claims violation of freedom of the press. All of which is a bunch of bosch.

Dr. Means is an ardent proponent of government medicine and a ringleader of groups supporting it. The A. M. A. contends that the article in question was a thinly veiled plug for socialized medicine and was misleading.

The A. M. A. was not obligated to carry the ad. In fact, it is not obligated to publish any ad. The right of free speech and freedom of the press were not abridged. Dr. Means had his essay in the *Atlantic Monthly*. The *Atlantic Monthly* sells copies to anyone having the cash. The A. M. A. did not have to act as a sales agent for the magazine. It did right in not being a party to the promotion of socialization propaganda.

TRUMAN COMMISSION ISSUES FINAL REPORT

Just as this issue of *The Journal* went to press, the final report of the President's Commission on Health Needs of the Nation was submitted to President Truman and copies released to the public.

Volume No. 1 of the report of the commission, better known as the "Magnuson Commission" because it was chairmaned by Dr. Paul B. Magnuson, Chicago, consists of 252 pages. It is a summary of the findings and recommendations of the commission on every conceivable aspect of health and health and medical services and facilities.

Officials of the Ohio State Medical Association have not had an opportunity to analyze the report. This will be done at an early date. Time and space will not permit a story on the report in this issue. Material from the report will be published in later issues.

On December 18, the day the report was released, a statement was issued to the press by the American Medical Association reading in part as follows and which indicates that some of the findings and recommendations of the commission will be subjects of heated controversy and debate during ensuing months:

"Dr. Louis H. Bauer, Hempstead, N. Y., President of the American Medical Association, said

"particularly useful...
for the routine therapy
of the
menopause"[1]







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1. Perloff, W. M.: Am. J. Obst. & Gynec. *58*:684, 1949.

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today that one of the major recommendations of the President's Commission on the Health Needs of the Nation provides that 'the Federal government, through payroll deductions, would pay directly for the medical care of a large segment of the population.'

" 'This,' he added, 'is national compulsory health insurance.'

"The American Medical Association is withholding comment on the full report of the Commission, pending careful study of the document by a four-man committee appointed by the Board of Trustees.

"Dr. Bauer said that since this one recommendation is 'so obviously objectionable, we wish to call attention to it immediately.'

"He referred to Point 4 of the recommendations which reads:

" 'Funds collected through the OASI (Old Age and Survivors Insurance) mechanism be utilized to purchase personal health service benefits on a prepayment basis for beneficiaries of that insurance group, under a plan which meets Federal standards and which does not involve a means test.'

"Continuing, Dr. Bauer said:

" 'Although the Commission does not use the term, this proposal, in effect, recommends national compulsory health insurance.

"In this single recommendation, the Commission proposes that funds collected through the Social Security System be used to purchase medical care for beneficiaries (now four and one-half million) covered by that system. Under this plan, the Federal government, through payroll deductions, would pay directly for the medical care of an ever-increasing segment of our population, and our health services would inevitably be controlled by Big Government."

PHYSICIAN VETERANS AND THE MILITARY SITUATION

An American Medical Veterans Society was organized recently in Toledo at a meeting of physician veterans from various places in the middle-west, according to newspaper accounts. It is reported that Dr. Kenneth McCarthy, Toledo, was elected president, to serve until the June meeting of the American Medical Association in New York when officers will be selected on an annual basis.

Such an organization can be of real value in helping to straighten out kinks in military medicine, providing it assembles facts and offers constructive advice and recommendations. Obviously, it has the right to criticize but criticism without constructive alternative recommendations will not do much good.

There are rumors that some physician veterans believe the A. M. A. is against renewal of the Doctors' Draft Act and would do other things which would make World War II medical officers vulnerable for military duty at this time. This is not in line with the facts.

The A. M. A. House of Delegates has taken no action as yet on the question of renewal of the Doctors Draft Act. It is seeking more facts before doing so. Also, it is insisting that the armed services show proof that they are making efforts to bring about more economical and efficient use of physicians now in uniform. Obviously, this action is beneficial to physician veterans and sound in principle.

The present attitude of the A. M. A. is outlined in an article appearing on page 63 of this issue, based on actions taken by the House of Delegates at the recent Denver session of the A. M. A.

There is every reason to believe that the rights of physician veterans will be protected by the A. M. A. and that the suggestions of such physicians will be given studious consideration by A. M. A. officials in their dealings with the armed services, Selective Service and the Congress on this complex question.

TWO FEDERAL PROPOSALS YOU'LL WANT TO SUPPORT

Keep your eye on two measures which will be introduced into the next U. S. Congress, convening in January. The chances are you'll want to write to your Congressman and to Senators Bricker and Taft, endorsing them. Can't give you bill numbers now, but the substance will give you a clue.

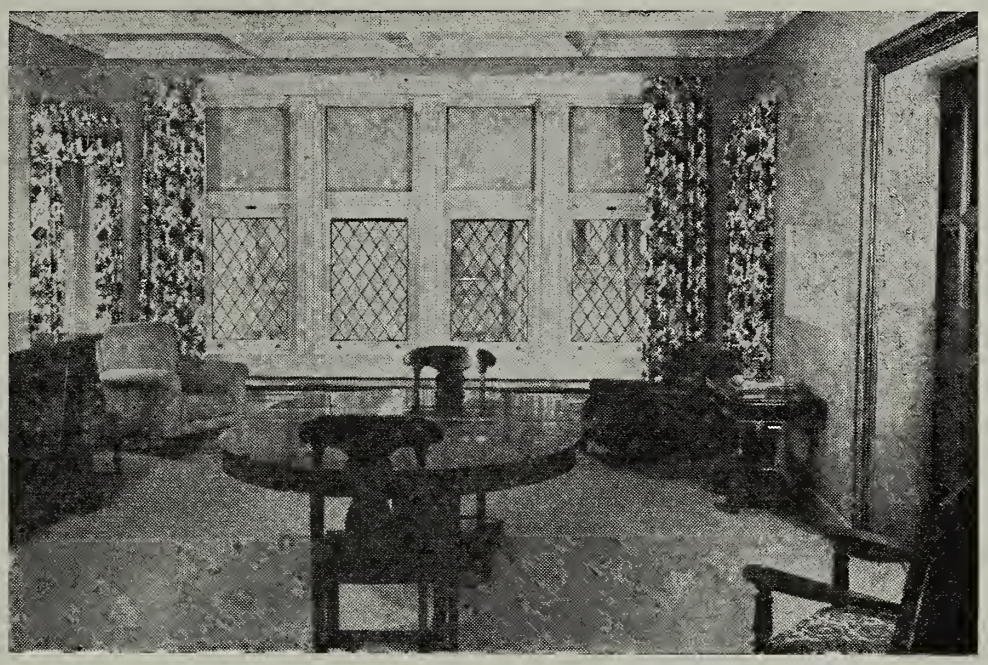
One will probably be known as the Reed-Keogh or Keogh-Reed Bill. It has the backing of many professional groups and other groups of self-employed, including the A. M. A. The basic provision of this measure (or twin bills) is that it would allow self-employed persons, not covered by existing pension plans, to defer taxes on income paid into a restricted retirement fund, organized by a group of persons, underwritten by an insurance company and approved by the Department of Internal Revenue.

The second measure will be a proposal for a Constitutional Amendment to protect the citizens of the United States against international treaties or United Nations agreements. The measure probably will be introduced by Senator Bricker of Ohio. Last session it had the verbal approval of some 60 U. S. Senators. Action at the coming session of Congress is expected.

The proposed amendment is aimed at agreements which may be reached in such organizations as the International Labor Organization and certain sub-agencies of the United Nations. The amendment which would be submitted to the states for ratification, if Congress passes the resolution, would probably do the following: (1) Provide that no treaty is valid which conflicts with the Constitution of the U. S.; (2) no treaty shall be effective until implemented by legislation; (3) no such legislation shall be valid if contrary to or in excess of the powers delegated to the Congress by the Constitution.

I. L. O. has been a proponent of international socialized medicine. The A. M. A. recently recommended that the United States withdraw from I. L. O. Acceptance of a treaty requires only a

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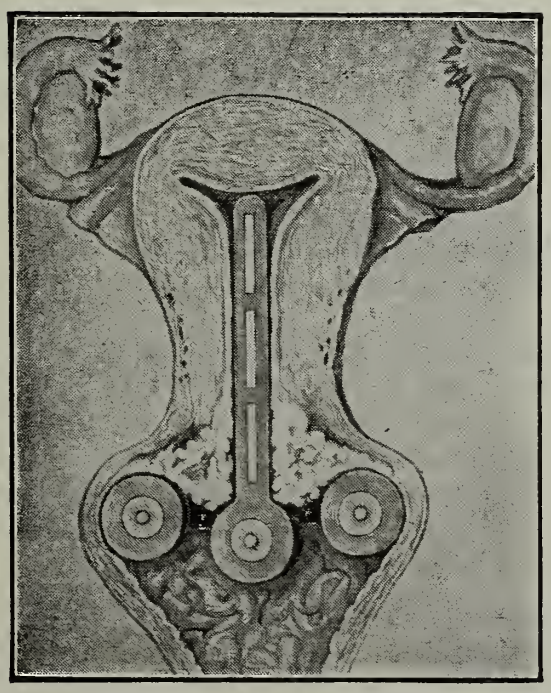
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majority vote in the U. S. Senate. The proposed constitutional amendment would make it impossible for a "leftish" Senate to ratify a treaty unless the three provisions enumerated above have been met. It would be a real backstop against socializing medicine in the U. S. through the side door.

BETTER GET THIS CIVIL DEFENSE MANUAL

Federal Civil Defense Administration has issued a comprehensive manual to guide state and local civil defense officials in getting matching Federal funds for health, special weapons, and other protective programs. The publication, *Federal Contributions*, is available at $1 a copy from the Government Printing Office, Washington 25, D. C.

It is suggested that Ohio physicians engaged in local Medical Civil Defense activities secure a copy of this manual. The manual goes into details. For example, it recommends specific medical supplies and equipment for a first aid station, for a 200-bed improvised hospital and for a blood donor operation. It also sets forth legal and policy limitations and procurement procedures.

Some of the criteria in order to get Federal funds include:

1. Medical supplies and equipment must be stored in a critical target area or within a radius of approximately 50 highway miles from the nearest boundary of such area.

2. Critical target area states must provide at least 50 per cent of their supply and equipment requirements for the first aid system before consideration can be given to requests for other health items.

3. Medical supplies and equipment will be limited to standard items listed in the manual.

4. Such supplies and equipment may be used for civil defense training only when such training does not jeopardize their ready availability in good condition for use.

The report states that no contributions will be made for supplies and equipment used for training purposes when they are available in (a) first aid courses given by the American Red Cross and the Bureau of Mines, (b) the 80-hour course of the ARC for volunteer nurses aides or (c) hospital training courses which can be given in existing hospitals.

The Veterans Physicians Society of Greater Cincinnati adopted a resolution at its November meeting in which it advocated renewal of the Doctors Draft Act upon its expiration in July. It also deplored what it termed the A. M. A.'s opposition to reenactment of the Act. Approximately 120 persons attended the meeting.

American Academy of General Practice To Meet in St. Louis, March 23-26

The Fifth Annual Scientific Assembly of the American Academy of General Practice will be held at St. Louis, Missouri, March 23-26.

The Academy returns to St. Louis in 1953 with the biggest anticipated registration in its history —but with no increase in the number of available hotel rooms, officials warned. This means that the physician who makes his reservation early will have first choice on the best rooms in the better hotels.

A complete program, listing the speakers, will be available soon. It will include such names as Dr. Richard Cattell, of Lahey Clinics; Dr. Crenston Holman, New York City; Dr. Gradie R. Rowntree, Louisville, Kentucky; Dr. Elmer Hess, Erie, Pennsylvania; Dr. Arild Hansen, University of Texas; and Dr. Pinson Neal, University of Missouri. No less than 60 Scientific Exhibits have been selected for their educational value, many of which have been especially created for this assembly, all of which will be closely integrated with the formal lecture program.

Mr. Leonard Reed, president of the Foundation for Economic Education, Irvington-on-Hudson, New York, will be the annual banquet speaker on March 25, with Dr. Edward E. Haddock, president of the Virginia Academy of General Practice, in the capacity of toastmaster.

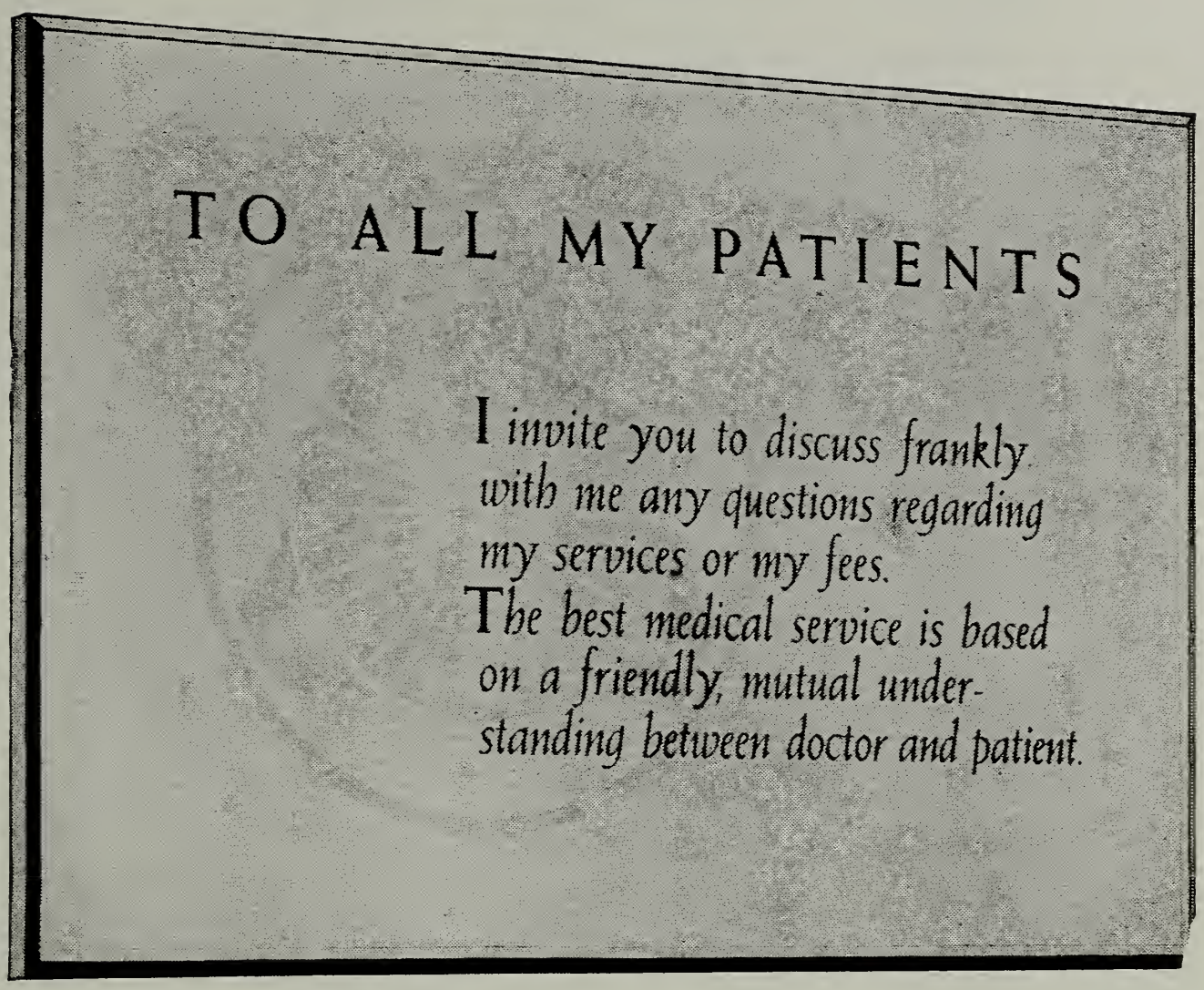
All members of the medical profession are invited to attend. A program of entertainment is planned for the ladies.

All requests for reservations must be made by February 23, through the Housing Bureau: Hotels Convention Reservation Bureau, A. A. G. P., Room 406, 911 Locust Street, St. Louis 1, Mo. All must list first, second and third hotel choice; give name and address of each occupant of the room, and, must give the time of arrival and anticipated departure time.

Industrial Health Meeting To Be Held in Chicago

Improving health services of our nation's working force will be the over-all theme of the Annual Congress on Industrial Health, sponsored by the A. M. A.'s Council on Industrial Health. Workers, industrial leaders and medical men will assemble for this 13th annual conference January 21-22 at the Drake Hotel, Chicago.

Highlights of the Congress include sessions on small plant industrial health services, human relations, and aspects of occupational cancer. One important session will endeavor to answer the question—how can management, labor and medicine best help maintain the health of our national work force?



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Yes, doctor, the best medical service is based on friendly, mutual understanding between doctor and patient. To help you create better public relations, the American Medical Association is making available—as a service to its members—an attractive new plaque to be displayed on an office desk or wall. This plaque will open the door to better relations with your patients because it encourages questions regarding professional services and fees. Price is one dollar—order yours today. Fill out the coupon and send to *order department*

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New Members of O.S.M.A.

Following are the names of new members of the Ohio State Medical Association since December 11, 1952. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY
Kretchmer, Henry E., Cleveland
Matowitz, Clayton C., Cleveland
Stanford, Hubert E., Cleveland
Stecker, Arthur I., Euclid
Thanos, Daniel, Cleveland

FRANKLIN COUNTY
Carroll, Paul T. Columbus
De la Motte, G. Walter, Columbus
Dickens, Dale R., Columbus
Ebert, Ray E., Columbus
Gaenge, William G., Cincinnati
Groff, Elmer M., Lt. (jg), Military Service
Hamelberg, Wm., Jr., Lt. (jg), Military Service
Keith, Luther M., Jr., Columbus
Matson, James E., Lt. (jg), Military Service
Miller, Mary Alice, Columbus
Philpott, William H., Columbus
Rauch, Robert F., Columbus
Southard, Martha Ellen, Columbus
Zartman, Edwin Ray, Columbus

KNOX COUNTY
Bogardus, Thomas L., Mt. Vernon
McLarnan, James C., Mt. Vernon

LUCAS COUNTY
Bradford, Brian, Toledo
Watson, Charles W., Toledo

MAHONING COUNTY
Bennett, H. N., Youngstown
Bernstein, Leon L., Youngstown
Friedrich, Frederick A., Youngstown
Jones, Edward H., Jr., Youngstown
Rodin, Robert, Youngstown

MEDINA COUNTY
Zito, Andrew J., Wadsworth

SANDUSKY COUNTY
Smith, James M., Bellevue

SUMMIT COUNTY
Kidney, James J., Akron

Widow of Doctor Sets Up Scholarship Fund for Medical Students

A memorial fund that will keep at least one student in medical college each year over a period of 32 years has been set up in Marion.

The memorial fund of $32,000 has been established as the result of a will left by Mrs. Florence M. Young who died November 29. The fund is to be known as the Dr. Fillmore Young Scholarship Fund, in honor of her late husband who died November 20, 1939.

To be eligible a student must have completed the requirements necessary for entry into an accredited medical school and must be a resident of Marion County. The student selected will be paid $1,000 a year for four years, and then another student will be picked. In other words, the fund will put eight students through medical training over a period of 32 years.

Assistant Director Needed by Red Cross in Columbus

The Columbus Regional Red Cross Blood Center, 812 E. Broad Street, is in need of Doctor of Medicine as assistant medical director on a full- or part-time basis. Physicians interested should communicate direct with Dr. Charlotte Winnemore, director, at the center.

Announcement

The Fifth Annual Scientific Assembly

of

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at

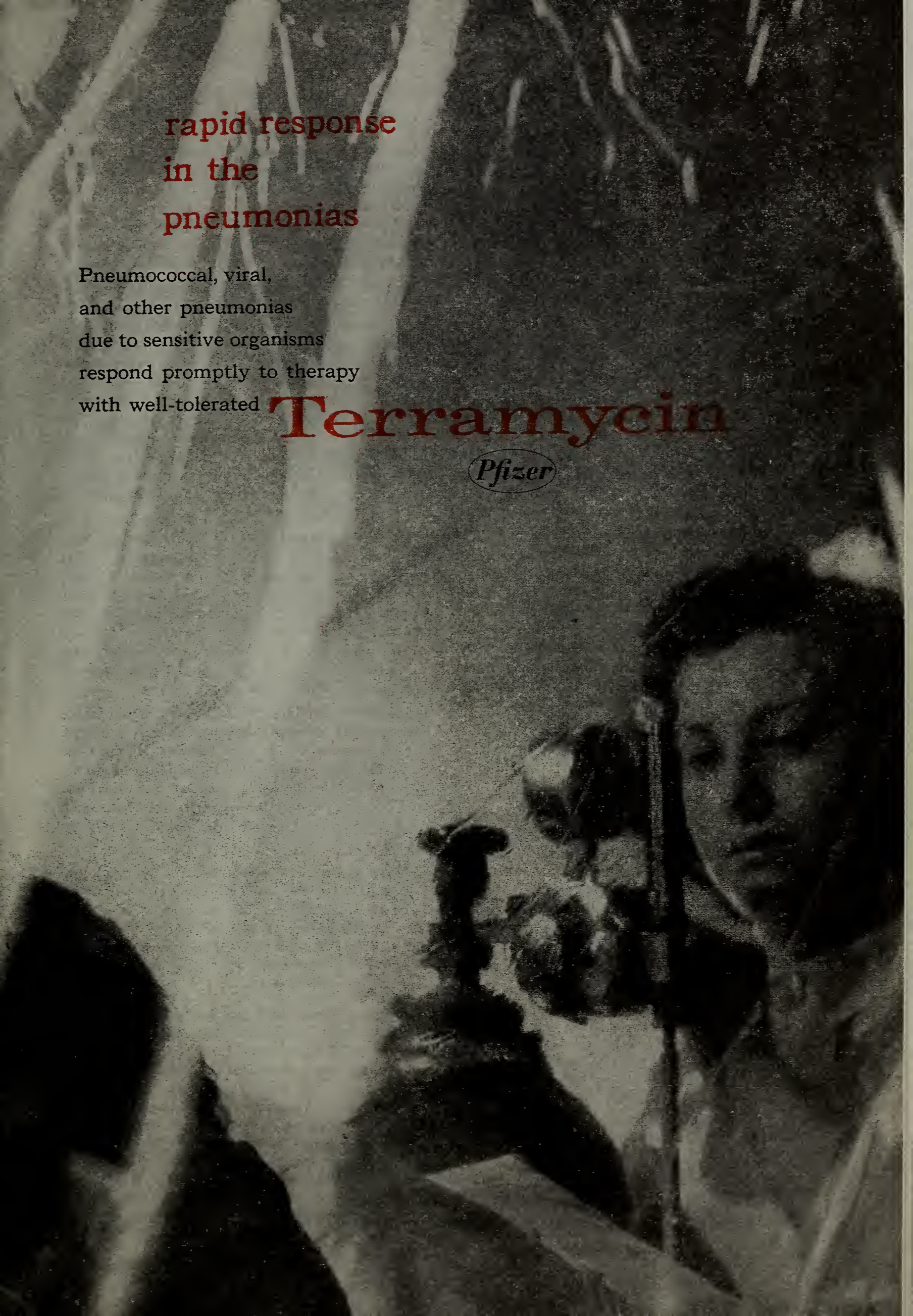
St. Louis, Missouri

MARCH 23-26, 1952

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In Memoriam . . .

Edmund C. Bell, M. D., Lodi; University of Toronto Faculty of Medicine, 1922; aged 62; died November 21; member of the Ohio State Medical Association; member of the American Medical Association; vice-president of the Medina County Medical Society for several terms and secretary in 1945-46. Dr. Bell moved to Lodi in 1928 and has practiced there since. In addition to his medical work, he took part in community affairs and was especially active in the Masonic Lodge and the Congregational Church. Surviving are his widow, a daughter and two sisters.

George Benzing, Jr., M. D., Hamilton; University of Cincinnati College of Medicine, 1922; aged 56; died November 4; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Radiology; member of the Radiological Society of North America, Inc., member of the American College of Radiology. Dr. Benzing had practiced for many years in Cincinnati. Surviving are his widow, a daughter and a son.

Daniel A. Berndt, M. D., Portsmouth; College of Physicians and Surgeons of Baltimore, 1896; aged 78; died November 3; member of the Ohio State Medical Association through 1951 and member of the American Medical Association through the same year; diplomate of the American College of Surgeons; delegate of the Scioto County Medical Society for several years. Dr. Berndt served virtually all of his professional career in Portsmouth with time out for postgraduate study in Europe. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. An early president of the local Medical Society, he also served as president of the Norfolk & Western Railway Surgeons Association. He was active in the local Rotary Club and in the International Rotary Club, in several Masonic orders and in the Methodist Church. Surviving are his son, Dr. A. L. Berndt, a daughter and a sister.

Myrwood T. Dixon, M. D., Columbus; Rush Medical College, University of Chicago, 1887; aged 89; died November 28; member of the Ohio State Medical Association through 1946. After practicing four years in Iowa, Dr. Dixon moved to Columbus in 1891. He went into semi-retirement in 1946. His long service was recognized when he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Affiliations included memberships in several Masonic orders. His widow survives.

Raymond E. Goewey, M. D., Berea; Syracuse University College of Medicine, 1924; aged 55; died November 8; member of the Ohio State Medical Association and member of the American Medical Association. Dr. Goewey moved to Berea in 1928 after serving on the staff of the State Tuberculosis Sanatorium at Mount Vernon. Affiliations included memberships in several Masonic orders. Survivors include his widow and three brothers.

Orlando E. Harvey, M. D., Lima; Ohio State University College of Medicine, 1912; aged 65; died November 27; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Harvey was superintendent of the tuberculosis hospital at Lima from 1931 to 1939. He also served at hospitals in Knoxville, Tenn., and at McConnelsville. He was a member of the Ohio National Guard, Torch Club, Fields National Literary Society, Elks Club, Masonic Lodge, Sertoma Club and American Federation of Musicians. Surviving are his widow, two sons and a sister.

Howard J. Hebble, M. D., Moorestown, N. J.; Jefferson Medical College Philadelphia, 1934; aged 43; died November 21. A native of Ohio, Dr. Hebble had been in practice for a number of years in Philadelphia while residing in Moorestown, across the state border. He was the son of Dr. and Mrs. R. C. Hebble, Springfield, and a brother of Dr. Joseph N. Hebble, also of Springfield. His widow also survives.

Eldred G. Holiday, M. D., Cadiz; Ohio State University College of Medicine, 1911; aged 69; died November 16; former member of the Ohio State Medical Association, last in 1929. A veteran of World War I, Dr. Holiday had practiced in Lore City and in Cambridge. He retired in 1929 from active practice. A sister and a brother survive.

Washington L. Jones, M. D., Youngstown; Wayne University College of Medicine, 1908; aged 69; died October 28; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Jones had practiced in the Youngstown vicinity for 44 years. His widow survives.

Joseph A. Link, M. D., Springfield; Medical College of Ohio, Cincinnati, 1898; aged 79; died November 17; member of the Ohio State Medical Association; member of the American Medical Association; the Clinical Orthopaedic Society; the American Academy of Surgeons, the International College of Surgeons, the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery; vice-president of the Clark County Medical Society in 1921. Dr. Link served virtually all of his professional career in Springfield, taking time out for post-

graduate studies in Europe on several occasions and for service during World War I. He attained the rank of lieutenant-colonel in the Army and later the rank of colonel in the Reserves. The Ohio State Medical Association honored him for his service with the 50-Year Pin and Certificate. Dr. Link's activities were numerous and included considerable work with crippled children's organizations. He was a member of the Masonic Lodge. Surviving are his widow, two brothers and three sisters.

William Harper Martin, M. D., Detroit, Mich.; Starling Medical College, Columbus, 1897; aged 81; died November 22. Dr. Martin had practiced for many years in Detroit. Survivors include a son, a daughter and two sisters.

John N. Merrick, M. D., Alliance; Ohio Medical University, Columbus, 1897; aged 84; died November 22. As an Army surgeon, Dr. Merrick served during the Spanish-American War, in the Philippines and during World War I. He was a resident of Alliance for 29 years. Surviving are his widow, a daughter and a step-daughter.

George W. Mosby, M. D., Columbus; Howard University College of Medicine, Washington, D. C., 1898; aged 79; died November 27; member of the Ohio State Medical Association; member of the American Medical Association. A practicing physician in Columbus for all of his career, Dr. Mosby had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Masonic Lodge, state treasurer of the Knights of Pythias and a member of the Methodist-Episcopal Church. His widow survives.

Robert S. Young, M. D., Los Angeles, Calif.; Columbia University College of Physicians and Surgeons, 1919; aged 66; died November 5; member of the Ohio State Medical Association; member of the American Medical Association; member of the American Urological Association; diplomate of the American Board of Urology. Dr. Young practiced for many years in Cleveland before he retired and moved to California.

A combined meeting of the Central Ohio Heart Association and the Staff of University Hospital, Columbus, will be held at the hospital on February 9 at 7:30 p. m. Dr. Franklin D. Johnston, University of Michigan, will speak on "Auscultation of the Heart." He will conduct a clinic at 11:00 a. m. on the same day.

Dr. Milton Rosenbaum, professor of psychiatry at the University of Cincinnati, has been named director of the Jewish Hospital's newly formed Department of Psychiatry. Other appointments at the hospital include Dr. Ira Abrahamson as director of ophthalmology, and Dr. Lee Rosenberg, director of the Department of Radiology.

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 16. Vaginal Approach to Pelvic Surgery, one week, starting March 2.

OBSTETRICS—Intensive Course, two weeks, starting March 2.

PEDIATRICS—Intensive Course, two weeks, starting April 6.

MEDICINE—Intensive General Course, two weeks, starting May 4. Electrocardiography & Heart Disease, two weeks, starting March 16. Allergy, one month and six months, by appointment.

UROLOGY—Intensive Course, two weeks, starting April 13. Ten-Day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY—Intensive Course, two weeks, starting May 11.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D. CINCINNATI)

CLINTON

Dr. Joseph H. Frame was elected president of the Clinton County Medical Society at its annual meeting in December at the General Denver Hotel, Wilmington. Dr. H. Richard Bath, was named vice-president, and Dr. Robert E. Suer was reelected secretary-treasurer.

HIGHLAND

The Highland County Medical Society met at the Chatterbox Restaurant, Hillsboro, December 3, with noon luncheon. Speaker for the occasion was Dr. David W. Heusinkveld, Cincinnati, Councilor of the Association's First District.

HAMILTON

Scheduled program for the Academy of Medicine of Cincinnati for January and February has been announced as follows:

January 6—"Headache," Dr. Irvin Levy, assistant professor, clinical neurology, Washington University School of Medicine, St. Louis.

January 20—"Surgical Correction of Diseases of the Mitral Valve," Dwight Narken, assistant professor of surgery, Tufts College Medical School, Boston; and "The Selection of Patients for the Surgical Treatment of Mitral Valvular Disease," Dr. Lewis Dexter, assistant professor of medicine, Harvard University Medical School, Boston. This will be a joint meeting with the Heart Council.

February 3—"Clinical Disturbances of the Pituitary Gland," Dr. Edward Rynearson, professor of medicine, University of Minnesota.

"Metabolic Bone Disease," Dr. Granville Bennett, professor of pathology, University of Illinois College of Medicine, Chicago.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

Dr. William H. Crays, Springfield, assumed office as president of the Clark County Medical Society at the November 17 meeting. Others elected to office are: Dr. J. H. Rinehart, president-elect; Dr. Francis C. Link, secretary; and Dr. Henry M. Tardif, treasurer. Dr. Martin J. Cook and Dr. Ray M. Turner, were elected delegates, and Dr. E. W. Schilke and Dr. J. Harold Shanklin, alternates.

DARKE

"Estate Planning for Physicians" was the subject of a talk by Robert R. Coppess, Greenville, at the November dinner meeting of the Darke County Medical Society at the Wiebusch Manor, Greenville.

GREENE

Dr. Frank Anzinger, Jr., Springfield, spoke on the subject, "Diagnostic Methods of Detecting Disturbances in the Adrenal Gland, with Discussion of ACTH and Cortisone," at the December 11 meeting of the Greene County Medical Society. The meeting was held at the Greene Memorial Hospital, Xenia.

MIAMI

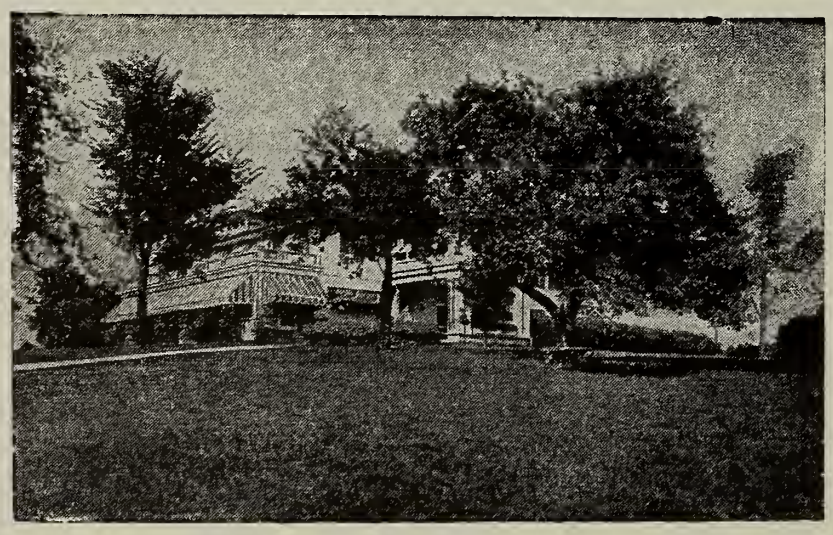
Dr. John A. Judy, Dayton, discussed "Medico-Legal Problems" at the November 7 dinner meeting of the Miami County Medical Society in the Stouder Memorial Hospital.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

The Lima and Allen County Academy in conjunction with the Van Wert and Putnam County Medical Societies, held a regular monthly meeting at the Shawnee Country Club on November



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18. Speaker was Dr. William D. Holden, professor of surgery, Western Reserve University School of Medicine, who spoke on "The Use of Radio-Active Isotopes in Studying Peripheral Vascular Diseases."

An election of officers was held and Dr. Fred P. Berlin, Lima, was voted president-elect for 1954. Dr. Laurence N. Irvin was elected secretary, and Dr. Melvin A. Mulvania, treasurer. Dr. W. Virgil Parent is the incoming president who takes office in January.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

DEFIANCE

The Defiance County Medical Society has given $500 to the American Medical Education Foundation.

The following officers were elected at the December 9 meeting: Dr. P. B. Newcomb, president; Dr. Harold J. Wensinger, vice-president; Dr. D. J. Slosser, secretary-treasurer. Dr. Slosser was named delegate and Dr. Wensinger, alternate.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Dr. Harvey T. Ricketts, professor of medicine at the University of Chicago, was guest speaker at the November 11 meeting of the Mahoning County Medical Society, in keeping with the Society's observance of "Diabetes Detection Week." Dr. Ricketts spoke on the subject, "Recent Developments in Diabetes and Their Bearing on Its Management." The meeting was held in the Hotel Pick-Ohio with Dr. C. A. Gustafson, president, and Dr. Morris S. Rosenblum, chairman of the Committee on Diabetes, in charge.

Members of the Society took an active part in a program sponsored by the Youngstown Hearing Society. At this meeting, Dr. Thomas L. Tolan, Marquette University Medical School, spoke on "Hearing Problems as Presented to Practicing Physicians."

SUMMIT

Dr. George J. Hamwi, associate professor of medicine, Ohio State University College of Medicine, Columbus, spoke on the subject, "Recent Advances in Endocrinology," at the December 2 meeting of the Summit County Medical Society in Akron.

TRUMBULL

The Trumbull County Medical Society held a joint dinner meeting with the Auxiliary on November 19 at the Trumbull Country Club. The Society had as its guest speaker, Dr. Alton Goldbloom, professor of pediatrics at McGill University who delivered an extremely interesting and philosophical talk on "The Evolution of Infant Feeding."—G. A. Sudimack, M. D., secretary-treasurer.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

The Belmont County Medical Society and Auxiliary held a dinner meeting on November 20 at the Belmont Hills Country Club. A movie, "Toxemia of Pregnancy," was shown with comments by Drs. N. S. Assali, S. T. Garber, and R. D. Bryant of Cincinnati. Dr. L. E. Herget, Cleveland, chairman of the Ohio Division, American Cancer Society, spoke on the subject of cancer.

The annual Christmas dinner meeting of the Society and Auxiliary was held at the Belmont Hills Country Club on December 18. The scientific part of the program consisted of medical movies.

HARRISON

Dr. Ross P. Rusk, Cadiz, was honored at a banquet of the Harrison County Medical Society on November 12 at the Cadiz Country Club. He was presented with the 50-Year Pin and Certificate of the Ohio State Medical Association, by Dr. R. J. Foster, New Philadelphia, Councilor of the Seventh District of the Association. Dr. Rusk has practiced continuously in the Cadiz vicinity.

At the business meeting the following officers were elected: Dr. Richard W. Weiser, Jewett, president; Dr. Gerald E. Vorhies, Scio, vice-president; and Dr. D. L. Tippett, Cadiz, secretary-treasurer.

Tenth District

(COUNCILOR: WM. F. MITCHELL, M. D., COLUMBUS)

PICKAWAY

Dr. A. D. Blackburn, Circleville, Pickaway County health commissioner, was honored for a half century of medical practice by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Presentation was made by Dr. William F. Mitchell, Columbus, Councilor of the Tenth District of the Association, at the December 3 meeting of the Pickaway County Medical Society.

ROSS

Dr. Norman D. Rothermich, Columbus, spoke on the subject, "Ballistocardiography," at the November 6 meeting of the Ross County Academy of Medicine in Chillicothe.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

The Lorain County Medical Society held its regular monthly meeting at the Pueblo, Lorain,

on December 9 with dinner. An address on "Recognition and Management of Cancer of the Lung," was given by Dr. Harvey J. Mendelsohn, Cleveland.

RICHLAND

Fifty-two members of the Richland County Medical Society have contributed $1,030 to the American Medical Education Foundation. Seven members have made contributions to their respective medical schools.

Woman's Auxiliary . . .

By MRS. JAMES E. MULLEN, Chairman, Publicity Committee, 572 E. Front Street, Perrysburg

President—Mrs. Paul Woodward, 1500 Hollywood Avenue, Cincinnati

President-Elect—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

Vice-President—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. Gaston Hannah, 180 E. Sharon Ave., Glendale

Treasurer—Mrs. C. E. Cassaday, 1106 Vine St., Mount Vernon

Past-President—Mrs. Farrell T. Gallagher, 1527 W. Clifton Blvd., Lakewood

CONTRIBUTIONS TO A. M. E. F.

Mrs. George Cooperrider, State Chairman of the American Medical Education Foundation, reported the receipt of contributions from the following county Auxiliaries: Fayette, Scioto, Trumbull, Huron, Belmont, Pickaway, Lawrence, Butler, Ottawa, Guernsey, and Mercer.

CHANGE IN CHAIRMANSHIP

Mrs. Frank Stevenson, 40 E. Fountain Avenue, Glendale, has been named State Nurse Recruitment Chairman.

* * *

ALLEN

Mrs. J. M. Knox, president of the Woman's Auxiliary to the National Medical Association, addressed the Lima and Allen County Auxiliary at a meeting held at the home of Mrs. Paul J. Stueber on Dec. 2. Her subject was "The World Health Organization." Wives of resident physicians and interns at St. Rita's and Memorial Hospitals were guests.

The geriatrics committee, of which Mrs. M. A. Mulvania is chairman, furnish entertainment and refreshments each month to the members of the Lima Y. W. C. A. Best Years Club. This club is composed of 35 women past 65 years of age.

Members of the Academy of Medicine entertained Auxiliary members at a Year-End dinner dance at the Shawnee Country Club on Dec. 11.

BUTLER

Problems in the treatment of tuberculosis were discussed by Dr. J. N. Christianson at the Nov. 18 luncheon meeting of Butler County

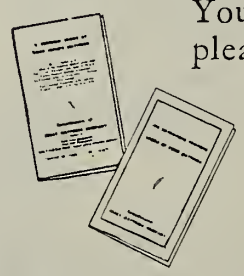


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Auxiliary at Hughes Memorial Hospital. It was voted to complete the radio installation in the Memorial Hospital, bringing it to three channels with six additional pillow speakers.

As part of its Health Education program, the Auxiliary is sponsoring a series of broadcasts entitled "Melody of Life." The broadcasts, which began on Nov. 17, will continue each Monday for 13 weeks, and will feature the life stories of 13 Music Masters, with sidelights on how they might have been aided through a health program. The program is made available through recordings furnished by the American Medical Association.

CRAWFORD

Officers of the Crawford County Auxiliary are: Mrs. Claude A. Lingenfelter, president; Mrs. D. D. Bibler, vice-president; Mrs. E. C. Brant, president-elect; Mrs. Carl J. Ide, secretary; and Mrs. Charles Griebling, treasurer. The candidate for the third nursing scholarship to be provided by the Auxiliary is at present enrolled in the School of Nursing at White Cross Hospital, Columbus, Ohio.

DELAWARE

Delaware County Auxiliary members entertained Union, Morrow and Knox County Auxiliaries at a luncheon at Bun's restaurant on Nov. 11. Mrs. E. J. Marsh, tenth district director, briefly discussed nurse recruitment. Mrs. Elizabeth August, R. N., secretary of the Ohio State Nurses Association, spoke on the Nurses' Loan Fund.

ERIE

During the month of October, the nurse recruitment committee of Erie County Auxiliary, with Mrs. R. H. Williamson as chairman, presented a program concerning nurses' training and other hospital services to students of Sandusky and other area high schools. Teams, composed of members of the nurse recruitment committee, nurses, x-ray technicians and laboratory technicians, visited the schools and presented the program to interested students.

To acquaint the mothers of the community with the services offered by the various health organizations, the Auxiliary presented a program to the Sandusky Federation of Mothers Clubs on Nov. 10. Mrs. Lester Parker, program chairman, explained the purpose of the session and introduced the panel of speakers. Miss Marjorie Valentine represented the local chapter of the Red Cross; Rev. Ralph Strobel, American Cancer Society; Mrs. Louis Schultz, the March of Dimes; Mrs. Catherine Michel, the Tuberculosis and Health Association and Mrs. Len Winkler, the Public School Health Program.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine met on Oct. 20 at the Columbus Gallery of Fine Arts. Mrs. Hugh Missildine introduced the speaker, Dr. Harold Grimm of Ohio State University, who spoke on "Our Challenge to Soviet Russia." Mrs. H. J. Wynsen was chairman of the tea which followed the meeting.

The wives of interns and residents of Columbus hospitals were honored at a tea on Nov. 11 sponsored by the hospitality committee. Mrs. James R. Gay opened her home for the event and was assisted by Mrs. Philip Hardymon, co-hostess, Mrs. Robert Schoene, president of the Auxiliary, and several other members.

The Nov. 17 meeting was devoted to nurse re-

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cruitment and honored prospective nurses and their mothers. Mrs. Charles Harding, Mrs. William Harding and Mrs. Damon Wetterauer and members of the Nurse Recruitment Committee planned the program which included a panel "The News in Nursing," with Miss Ann Gallagher, president of the Nurses Council, as moderator. Participants in the panel discussion were Miss Bernice O'Brien, president of the Columbus League of Nursing Education; Miss Eileen Downey, director of nursing, Benjamin Franklin Hospital; Miss Venoie Olson, supervisor of Polio Division at Children's Hospital and Miss Freda Stewart, assistant director of School of Nursing, Ohio State University. Mrs. Kenneth Brown was chairman of the tea.

GREENE

"The Bottom End," in which he described an epic journey to the Antarctic, was the subject of Mr. W. B. Alexander, vice-president and dean of administration at Antioch College, when he was guest speaker at a dinner meeting of the Greene County Auxiliary at the Trebein Manor on Nov. 19. Husbands of members were guests. Mrs. Robert D. Hendrickson, Mrs. Harvey McClellan and Mrs. W. T. Ungard were hostesses.

HAMILTON

Hamilton County Auxiliary held a luncheon meeting on Nov. 18 at the Town Club in the Hotel Sinton. Mr. James Bruce of Station WLW served as moderator of a panel discussion entitled "Are We Adequate Parents?" Participants on the panel were Miss Dolores E. Wagner of the Family Service Department of the Court of Domestic Relations; Dr. Jack Hertzman, director of health and hygiene in the Cincinnati public schools; Judge Otis E. Hess and the Rev. Benjamin F. Judd, minister of the Pleasant Ridge Presbyterian Church. Among the special guests at the luncheon was Mrs. I. Joseph Waxse, president-elect of the Woman's Auxiliary to the Kansas State Medical Association, a former Cincinnatian and guest of Mrs. Paul Woodward, State President.

Mrs. Harry L. Fry and Mrs. John W. Hauser were co-chairmen of the annual dinner dance held Dec. 6 at the Maketewah Country Club. The proceeds will be put into the educational and philanthropic fund.

HIGHLAND

Members of the Highland County Auxiliary met for luncheon at the Highland House on Nov. 5. The role of the doctor's wife with respect to Civil Defense and Public Health problems of her community was discussed by Mrs. J. Martin Byers, chairman of the civil defense committee. Mrs. Mortimer Herzberg, program chairman, described types of bomb shelters used and living conditions in England during World War II.

HURON

Huron County Auxiliary met on Nov. 14 at

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the home of Mrs. J. C. Steiner. Mrs. W. A. Drury was selected as secretary to replace Mrs. Jay D. Braddish who is moving to Columbus. Committee reports were given, and the group voted to contribute $60.00 to the American Medical Education Foundation.

Mrs. T. H. Smith presented a paper on Eisenhower's stand with regard to the welfare state.

LAWRENCE

Mrs. G. H. Spears was hostess to members of Lawrence County Auxiliary on Nov. 17. During the business meeting, conducted by the president, Mrs. Ray Swango, it was voted to contribute to the American Medical Education Foundation. Plans for the Christmas dinner, at which husbands will be guests, were completed.

Guest speaker was Dr. C. G. Polan, psychiatrist, who spoke on "The Role of a Doctor's Wife in Relation to His Patients."

LICKING

Mrs. Paul Grove was hostess to the members of Licking County Auxiliary at a casserole supper on Nov. 25. Following supper, Red Cross sewing was done and plans were made for a rummage sale on Dec. 2 and a Christmas party on Dec. 11.

LUCAS

Mrs. John Buck and Mrs. Hazen Hauman, chairmen of the 1953 Mothers' March on Polio, entertained in Mrs. Buck's home on Nov. 20 at a briefing meeting for section captains. Mrs. Buck participated in a panel discussion on the polio drive at a meeting in Columbus on Nov. 3.

Mrs. Emidio Gaspari, chairman of the Oct. 28 style show and tea, announced a net profit of $350.00, which will be used to purchase additional equipment for the kitchen.

The annual open meeting was held at the Academy Bldg. on Nov. 18. Mrs. Henry Brunsting, chairman of the program committee, introduced Dr. Fred Hodges, head of the Department of Radiology, University of Michigan, who spoke on "The Impact of Atomic Energy on Medicine." Mrs. Bernhard Steinberg and Mrs. E. Benjamin Gillette poured at the tea following the meeting.

The "Live Issues of Today" evening study group met at the home of Mrs. Theron Hopple on Dec. 5. The topic of discussion was "Price Control." The "Mental Hygiene" group met on Nov. 25 at the home of Mrs. J. B. Hirsch. "The Needs of the Pre-School Age Child" were discussed by Mrs. Clifford Reulein, consultant of the Family Life Education program, Board of Education, and director of Nathan Hale Pre-School Center.

The Board recently authorized the establishment of a three-year nursing scholarship in the amount of $300.00. The candidate will be chosen by means of a competetive examination given at

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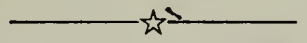
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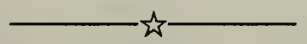
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the University of Toledo. Mrs. L. S. Pugh is chairman of the nurse scholarship committee.

MAHONING

Mahoning County Auxiliary was hostess to the members of the sixth district at a luncheon and style show at the Elk's Club on Oct. 29. Approximately 125 women attended from the six counties in the district. Mrs. W. O. Mermis, president, conducted a short business meeting and introduced the following state officers: Mrs. Paul Woodward, president; Mrs. N. M. Reiff, president-elect; Mrs. A. Paul Hancuff, vice-president; Mrs. M. T. Knappenberger, director of the sixth district; Mrs. Craig Wales, state civil defense chairman; and Mrs. William H. Evans, state program chairman. A dinner was held at the Pick-Ohio Hotel in the evening, at which Dr. Tennyson Guyer was the guest speaker.

A dance for the benefit of the Nurses' Scholarship Fund was held at the Squaw Creek Country Club on Nov. 15.

MARION

Following an annual custom, members of the Woman's Auxiliary to the Marion Academy of Medicine were joined by the Academy members for dinner in the ballroom of the Hotel Harding on Nov. 12. Guest speaker was Professor William C. Craig, head of the speech department at Wooster College, whose topic was "The Anatomy of the Pun." A musical program was presented by a vocal quartet from Harding High School.

The welcome was extended by Mrs. M. M. Weinbaum, vice-president of the Auxiliary, and the response was given by Dr. R. L. Gettman, president of the Academy. Mrs. James Greetham, director of the third district, was a guest.

OTTAWA

Members of the Ottawa County Auxiliary stuffed envelopes with Christmas seals for the County Tuberculosis and Health Association at the Nov. 20 meeting held at the home of Mrs. R. W. Minnick. Miss Florence Specht and Mrs. Richard Hotz, Toledo, were guests. Mrs. A. D. Miessner will supply the Christmas tray favors for the hospital. It was voted to contribute to the American Medical Education Foundation.

STARK

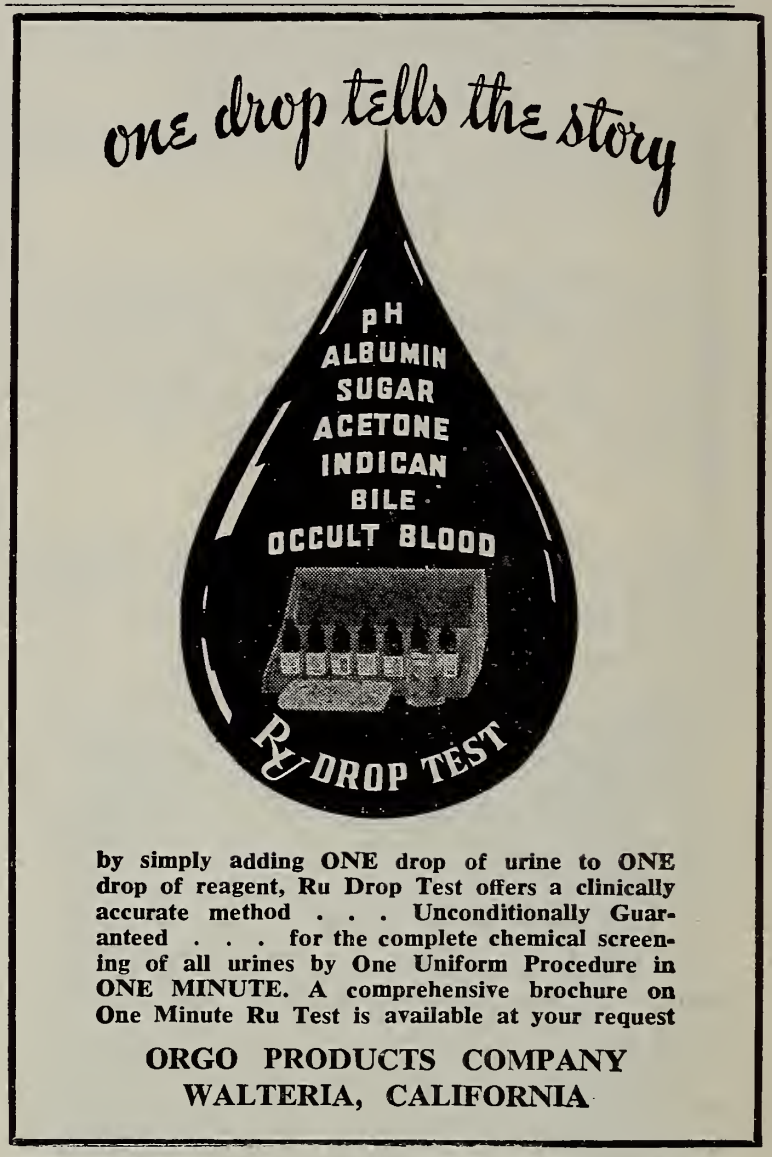
Mrs. S. B. Maxwell, chairman of the Nov. 1 dance sponsored by the Stark County Auxiliary, reported proceeds of $700.00, a portion of which will be given to the Nurse Scholarship Fund.

A panel discussion of "Problems of Raising Cain" featured the Nov. 11 meeting held at the Y. W. C. A. Dr. Harold Eibling, superintendent of Canton schools; Mr. L. J. Smith, head of the Massillon schools; and Mr. R. S. Schafer, superintendent of Alliance schools, presented the panel on problems in education.

The Auxiliary served tea on Nov. 12 and again on Nov. 26 to the Live-Long-and-Like-It group at the Canton Public Library.

TRUMBULL

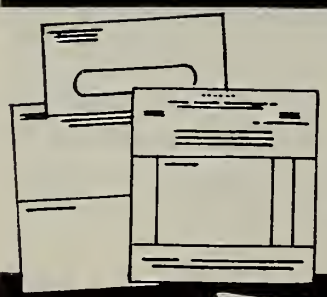
The Trumbull County Medical Society and Auxiliary held a combined dinner meeting in November at the Trumbull Country Club. Dr. R. P. Ostergard introduced the speaker, Dr. Henry Goldbloom, Professor of Pediatrics at McGill University, whose subject was "The Evolution of Infant Feeding." During the business session of the Auxiliary, it was voted to contribute funds to the American Medical Education Foundation, the Tuberculosis and Health Association and the Community Fund drive.



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Washington Roundup . . .

Dr. Joseph F. van Ackeren has been named Chief Medical Officer of the Coast Guard, succeeding the retiring Dr. Paul M. Stewart. Dr. van Ackeren will hold the rank of Assistant Surgeon General.

* * *

An Agriculture Department chemist - entomologist team reports that it has produced experimentally a virtually invisible and longer-lasting insect-killing mixture by mixing lindane with a chlorinated polyphenyl.

* * *

American employers are paying close to a billion and a half dollars a year for employee health and life benefits according to a U. S. Chamber of Commerce survey of "fringe benefits," or labor costs not shown on the actual payroll.

* * *

Despite the highest ratio of physicians to population of any country (1 to 495), Israel has the same problem as the United States in getting physicians to practice in rural areas according to Israel's Minister of Health, Joseph Burg, Ph. D. Based on number of physicians according to 1951 A. M. A. Licensure report, the U. S. ratio is 1 to 730.

* * *

Federal Food and Drug Administration has obtained its first injunction under new prescription-control law, target being Renesol Corp., a Jersey City mail order firm, which is enjoined from mailing a phenobarbital compound to persons having no physician's prescription.

* * *

Elizabeth Healy Ross, a psychiatric social worker and wife of the director of international affairs for the C. I. O., has been named to the new position of deputy chief of the U. S. Children's Bureau. She will serve directly under Dr. Martha M. Eliot, Bureau chief.

Architects and engineers responsible for the location of x-ray equipment in hospitals and clinics will find use for National Bureau of Standards Handbook 50, designed as a guide in setting up essential protective barriers. Available from the Bureau, Washington 25, D. C., for 15 cents.

* * *

Indications are that the incidence rate of poliomyelitis for 1952 will be about 35 per 100,000 estimated population. This compares with 28 in 1949, and 42 in 1916, the year of highest fatality rate as based on reports from 28 states.

* * *

Incidence of meningococcal infections for the disease year ending September 1, was 18 per cent higher than for the previous year and a continuation of the upward trend which began in 1948.

* * *

The 1951 death rate for the U. S. was 9.7 per thousand population, approximately the same as in 1950 according to a preliminary estimate based on a 10 per cent sample of death certificates.

* * *

U. S. Chamber of Commerce is polling its members to determine whether they favor reorganization of social security machinery to provide for (a) combining all programs into one pay-as-you-go plan covering all employed, (b) paying benefits to all retired aged, and (c) eliminating Federal subsidies to states for old-age assistance.

* * *

Better medical care is given by the U. S. Census Bureau as one reason for a rapid increase in the number of persons over 65 years of age. The Bureau's latest check indicates that one in 12 was 65 or older in 1951; fifty-years ago the ratio was one in 25.

* * *

Dr. Arden Freer is retiring as Deputy Chief Medical Director of the Veterans Administration,

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to be succeeded by Dr. Roy Wolford, Assistant Chief Medical Director for Professional Service.

* * *

National Advisory (Rusk) Committee to Selective Service recommends that medical graduates be made available for military service after one year of internship, and not be deferred for residencies.

* * *

The Gorgas Medal for "distinguished service in preventive medicine for the armed forces" has been awarded to Dr. James S. Simmons, wartime chief of preventive medicine for the Army and now dean of Harvard School of Public Health.

* * *

Latest information from the National Blood Program indicates monthly procurement from all sources will have to total 650,000 pints, or 8 million pints a year, if all needs are to be met.

* * *

At least 85 per cent of U. S. troops wounded in Korea are being returned to active duty within an average of three months, according to the Army Surgeon General, in a recent press conference. He said rate of death of the wounded was 2.4 per cent, the lowest in any war, attributed to fast evacuation and early surgery. Of 71,500 wounded, 62,500 have returned to duty; 4,500 are in Army hospitals; 3,000 discharged for disability; and 1,500 have died of wounds.

* * *

Conferences have been held recently in New York and Washington on gamma globulins. Problems discussed included: expanding production, controlling distribution, regulating price, monitoring prophylactic performance and other items necessary to the development of a plan to cope with possible tremendous demands for the substance.

* * *

Dr. Winchell McK. Craig, Ohioan, Mayo Clinic neurosurgeon, and a rear admiral in the Naval Medical Reserve, has been installed as president of the Association of Military Surgeons to Succeed Maj. Gen. Harry G. Armstrong, Air Force Surgeon General.

* * *

Rep. H. R. Gross (R., Iowa), who recently protested use of public funds to send Oscar R. Ewing on a trip to India, says he will sound off further on junketeering when House convenes in January.

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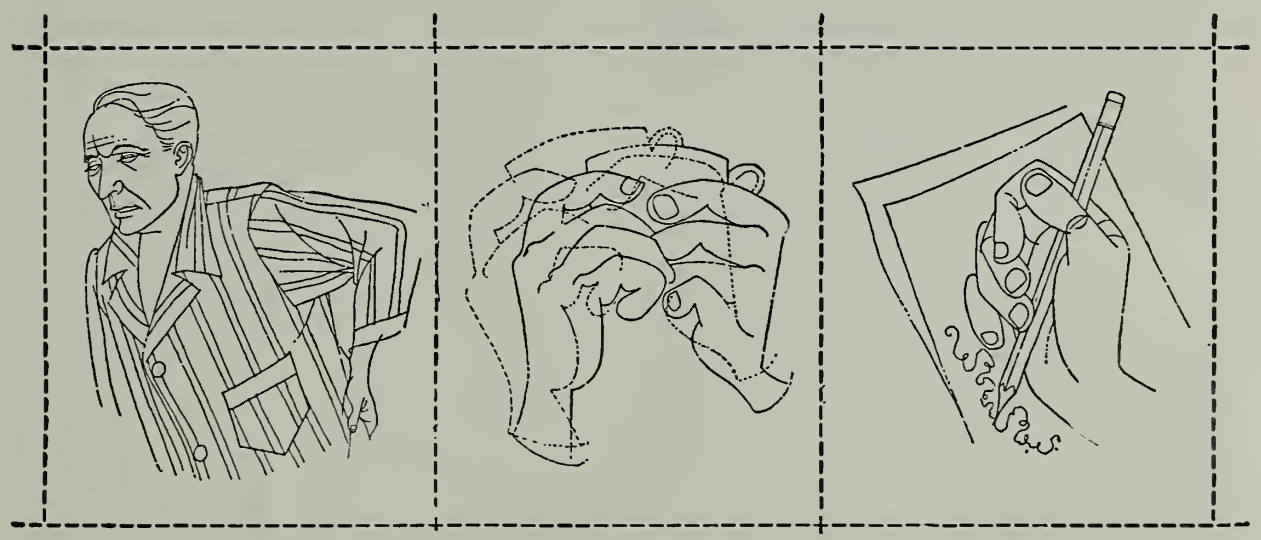
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Emotional Factors in Cardiovascular Diseases, by Edward Weiss, M. D., ($2.25. Publication 97 in the American Lecture System. *C. C. Thomas, Springfield, Ill.).* From a sound view so infrequently expressed today, the author does not ask us to study the *soma* less, but only to study the *psyche* more, than has been our custom in the past. In this way we have only a reaffirmation of an idea that is as old as the art of Medicine itself. Psychobiology gives us facts on which we can begin to build a mass of proven knowledge that can be established as Scientific. What we can get to add to it from the analysis of the thoughts, mental reactions, and dreams of a sick nervous system remains to be seen.

In spite of the enormous incidence of heart disease, the majority of patients who have symptoms which they refer to the heart region do not have heart disease of an organic nature. That anxiety and worry should affect the circulation is not to wonder at. The race has known of this almost since the beginning. The broken heart and age-old other terms linking the heart with love, courage and hate are abundant in every language. The author has covered the subject in a most satisfactory manner in nine chapters and 84 pages.

Cardiac Therapy, by Harold J. Stewart, M. D., $10.00. *Paul B. Hoeber, Inc., Medical Book Dept. of Harper & Bros., New York 16, N. Y.),* is a complete guide to the treatment of heart disorders and as such is devoted entirely to the care of cardiac patients. The treatment of each type of heart disorder is comprehensive and up to date. The emphasis throughout is on tailoring the treatment to the patient.

Correlative Cardiology, by Carl F. Shaffer, M. D., and Don W. Chapman, M. D., ($9.50. *W. B. Saunders Co., Philadelphia, Pa.),* is designed to correlate the phases of anatomy, pathology, and abnormal or pathologic physiology that pertain to the diagnosis of cardiac disease. In short, an integration of cardiac function and the management of cardiac disease.

Essentials of Dermatology, by Norman Tobias, M. D., ($6.00. Fourth Edition. *J. B. Lippincott Co., Philadelphia, Pa.),* is a working, handy volume for the practitioner. Diagnosis is stressed and the treatment recommended is modern. Illustrations are numerous and good.

Physician's Handbook, by Drs. M. A. Krupp, N. J. Sweet, E. Jawetz, and C. D. Armstrong, ($2.50. *Lane Medical Publications, University Medical Publishers, P. O. Box 1215, Los Altos, Calif.).* In this seventh edition of the San Francisco houseman's manual, we have a ready source of information, laboratory aids, and clinical helps for all the services in the hospital.

Research in Endocrinology, by August A. Werner, M. D., and his associates. (Published privately. Apply to the author, *403 Humboldt Bldg., Grand & Washington, St. Louis 3, Mo.).* This is a report of the work of a distinguished endocrinologist for the past 14 years and is based upon six texts and 52 papers. The 15 most important are reproduced. Over 40 years of clinical practice has also gone into this effort.

The Changing Culture of a Factory, by Elliott Jaques, M. D., Ph. D., with collaboration of colleagues from the Tavistock Institute of Human Relations, ($4.25. *The Dryden Press, Inc., New York 16, N. Y.),* presents a detailed description of the social organization of one factory and of the events that have occurred in that factory. Moreover, it gives an astute analysis of the apparently essential conditions under which these events have occurred. It is the stuff of which our social knowledge is made. Out of all of this grows some "If . . . then" principles as applicable to American factories as they are to this British works.

Communicable Diseases, by Nina D. Gage, R. N., John Fitch Landon, M. D., Helen T. Sider, R. N., with the collaboration of Grace M. Longhurst, R. N., and George F. Hoch, M. D., ($4.50. Sixth Edition. *F. A. Davis Co., Philadelphia 3, Pa.),* intended for use as a text by nurses, previous editions have enjoyed great popularity. This edition adds the story of anthrax, virus pneumonia, Q. fever, and a revision of the chapter on the nursing of tuberculous patients.

A **Textbook of Pharmacology,** by William T. Salter, M. D., ($15.00. *W. B. Saunders Co., Philadelphia, Pa.),* is devoted to the principles and application of pharmacology to the practice of medicine. Out of the great mass of material involved in this field, the author has selected the things which his experience has taught him will be useful to the medical student and the up-to-date physician.

The Principles and Methods of Physical Diagnosis, by Simon S. Leopold, M. D., ($7.50. *W. B. Saunders Co., Philadelphia 5, Pa.).* Also contains a chapter on "Sounds from the Thorax: Acoustic Principles," by S. Reid Warren, Jr., Sc. D. in E. E. This volume attempts to overcome one of the fundamental faults in most of the texts on Physical Diagnosis, i.e. the lack of

attention to the underlying principles — the physics of the examination and too much space to attenuated and emasculated clinical descriptions of diseases.

Bacteria, by K. A. Bissett, D. Sc., ($4.00. *Williams & Wilkins Co., Baltimore 2, Md.)*, presents a natural history of bacteria. The author attempts to correct one of the greatest defects in systematic bacteriology, i. e. the lack of fundamental background of biological knowledge such as exists in botany and zoology.

Surgical Technique, by Stephen Power, F.R.C.S., ($6.50. *J. B. Lippincott Co., Philadelphia, Pa.)*, is an attempt to bridge the gap for the young surgeon between the standard texts on Surgery and the "Vade Mecum's."

The Surgeon's Quest, by Lucille Vello, ($3.00. *William-Frederick Press, 313 W. 35th St., New York, N. Y.)*. Out of the unbridled lusts and passions of life the author has written her first novel. It well may be called a novel of adult living—if life in New York can be called living. It deals, as the jacket says, with the realizations that come with the circumstances that shallow men call disillusionment and wise men call maturity.

Congo Cameos, by Catherine L. Mabie, M. D., ($2.50. *Judson Press, 1701 Chestnut St., Philadelphia 3, Pa.)*, tells of the notable service of the author in Africa. Dr. Mabie is an honored person among American Baptists. Her stories are graphic descriptions of the interesting parts of a missionary's life.

The Cytology and Life History of Bacteria, by K. A. Bisset, Ph. D., ($3.50. *E. & S. Livingstone, Ltd., Edinburgh, Scotland,* publishers. Distributed by *Williams & Wilkins Co., Baltimore 2, Md.)*, presents a reasoned case for regarding bacteria as living cells with the same structure and function as other living cells. It also correlates the available information upon the various types of bacteria. It will be helpful to all biological workers in whatever field to get this contact with so large a body of evidence so generally not known to them.

The Pathology of Diabetes Mellitus, by Shields Warren, M. D., and Philip M. Le Compte, M. D., ($7.50. Third Edition. *Lea & Febiger, Philadelphia 6, Pa.)*, is illustrated with 112 cuts and three colored plates. In its revision contains much new material on experimental diabetes and our advances in knowledge of the special pathology in the related kidney, eye, and ductless glands.

The Low-Calory Cookbook, by Bernard Koten, ($2.95. *Random House, Inc., 457 Madison Ave., New York 22, N. Y.)*, gives 348 never failing recipes for people who love good food. This is the first book of its kind that is a part of a dreary diet. It, in full, treats of foods for the gourmet such as braising meat and vegetables without fat; baking pastries and cakes without shortening, or flour or sugar; drinks, canapes, soups, entrees, salads, desserts—all non-fattening and all suitable for the most vigilant guardian of his waistline!

First Annual Report on Stress, 1951, by Hans Selye, M. D., ($10.00. *Acta, Inc., Medical Publishers, 5465 Decarie Blvd., Montreal 29, Canada)*, represents the first of a series of annual supplements to the book Stress—The Physiology and Exposure to Stress, by the same author. The book is not the usual dull abstract but a correlation of pertinent facts as seen by the author. This is a most welcome addition to our library for certainly the average physician who needs to and wants to keep up on the developments in the study of the adaptation syndrome and yet this annual digests over 3000 references.

Diseases of the Skin, a Manual for Students and Practitioners, by Robert McKenna, ($8.00. Fifth Edition. *Bailliere, Tindall and Cox, London*: American Distributors *Williams and Wilkins, Baltimore, Md.)*, gives us a concise yet clear description of all of the more common of the diseases of the skin with careful instruction as how to separate from similar lesions, and dogmatic direction in regard to the treatment.

Backgrounds of Human Fertility in Puerto Rico, a Sociological Survey, by Paul K. Hatt *(Princeton University Press, Princeton, N. J.)*. In the broadest terms, this study indicates that changes presently occurring in Puerto Rico are tending in the direction of lower fertility. Moreover, it seems plain that the basic desire for smaller families is already widely present on the Island. Any increases both in the desire for, and the opportunities for, educational and economic advance should accelerate the fertility decline. Further, any increase in male paternal responsibility and female equality should have similar consequences. It also seems probable that attention to housing, medical, and family problems in rural areas would make further contributions to the decline.

Physics and Medicine of the Upper Air, a Study of the Aeropause, edited by Clayton S. White, M. D., and Otis O. Benson, Jr., M. D., ($10.00. *The University of New Mexico Press, Albuquerque, New Mexico)*, being the proceedings of a Symposium on Physics and Medicine of the Upper Atmosphere held in San Antonio, Texas, in November, 1951. Some 34 of our leading scientists have assembled what we do know and outlined what we ought to know about man's capacity to man modern aircraft as it takes us into enviromental frontiers beyond which our knowledge at best is incomplete and at worst totally lacking.



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JONATHAN FORMAN, M. D., *Editor*

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Leukoplakia of the Urinary Tract Treated by ACTH
Report of a Case

IRVING HELFERT, M. D., and HARRY A. BREMEN, M. D.

LEUKOPLAKIA is a disease of undetermined etiology involving mucous membrane. It is characterized by an epidermoid metaplasia in various stages of keratinization, and, histologically, the end result closely resembles normal skin.

In a review of the literature we have found fewer than two hundred cases of leukoplakia involving the urinary tract, and no evidence of satisfactory medical management of this condition.

Though the true etiology remains obscure, opinion has strongly favored chronic infection and/or chronic irritation as the most likely cause. Armstrong noted that 'focal infection, local or distant, precedes or accompanies almost every case';[1] Low reported a case which he regarded as unique because, among other reasons, there was no urinary tract infection present and no history of such infection.[2] Until recently it was generally agreed that leukoplakia is a precursor of cancer, but that belief is no longer unchallenged. However, the condition has continued to be considered irreversible.[3]

CONFUSING SYMPTOMS

Diagnosis may offer considerable difficulty. Clinically, the diagnostic picture may be confused by such symptoms as loss of weight, chills, fever, nausea and vomiting, together with renal colic which appears unheralded, incapacitates the patient for a variable length of time, but disappears with dramatic suddenness either spontaneously or immediately after ureteral catheterization. X-ray is likely either to reveal no abnormality whatsoever or else to give the impression of malignancy. Smears and cultures of the urine frequently are of no additional diagnostic value, and the diagnostician may be at a loss to account for the excruciating pain experienced by the patient.

Many investigators have considered diagnosis prior to surgery highly improbable, if not impossible.[1, 3, 4] We have found reports of only two cases involving the renal pelvis which were recognized before surgery.[2, 5] However, the appearance in the urine of desquamated epithelial tissue should make one suspect the presence of leukoplakia; in fact, McCrea regards this finding as pathognomonic.[4] If the condition is confined to the bladder, such passage of tissue may be the only dependable diagnostic sign; where the kidney is affected renal colic is an additional symptom. In either instance, recognition of the disease by pathological study may be greatly delayed, and even securing the tell-tale tissue for laboratory examination requires careful vigilance.

In the past, nephrectomy has been advocated as the treatment of choice when the condition

Submitted August 30, 1952.

The Authors

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is unilateral.[1, 4] Bilateral involvement has been treated symptomatically with supportive measures and medicaments such as irrigation with silver nitrate, salicylic acid,[1] or zephiran.®[3] Massive doses of vitamin A and aureomycin have also been used.[5] But to date we have been unable to find report of any medication to which the disease has yielded.

Judging from the literature, the bladder is the most common site of leukoplakia in the urinary tract, and the renal pelvis is less commonly affected, while it is estimated that in only 10 per cent of the latter cases is the bladder also affected.[1] Bilateral involvement of the kidneys accompanied by leukoplakia of the bladder is therefore rare. It is such a case, now in remission for nine months, which we wish to report.

CASE REPORT

The patient, a 41 year old white married male, employed as a railroad trackman, was admitted to Miami Valley Hospital, Dayton, Ohio, on January 20, 1951, complaining of colicky left flank pain which radiated to the left testicle.

Past history: This patient had passed 'flakes' in his urine intermittently for 18 years. He dated this condition from instillations for an urethritis of unknown etiology. During the eight years preceding admission he had experienced six attacks of left renal colic associated with chills, fever, nausea, vomiting, and the passage of 'flakes.' At no time during this period had a complete urological investigation been made.

Examination: Physical examination revealed a well developed, well nourished man lying in bed, writhing in pain. His height was 5 feet and 11 inches, weight 178 pounds, temperature 103°F., pulse 110, respirations 24, blood pressure 140/80. There was exquisite localized tenderness in the left flank. The remainder of the general physical examination was non-contributory.

A complete blood count was normal. The urine on analysis showed a specific gravity of 1.012; there was a trace of albumin; no sugar or acetone; on microscopic examination of the sediment, 10 and 12 red blood cells and 6 to 8 white blood cells per high power field were found. There were a few epithelial cells.

Intravenous urogram demonstrated no abnormalities. Retrograde pyelogram showed a questionable mottling in the inferior calices of the left kidney; the right kidney appeared entirely normal. At this cystoscopic procedure a small piece of desquamated tissue was observed as it was emitted from the *right* ureteral orifice. This first suggested a diagnosis of leukoplakia. The fragment of tissue was submitted for pathological study, and the laboratory report was consistent with the clinical impression.

Since the patient presented left-sided symptoms and the fragment of tissue had been obtained from the right side, it was felt justifiable to make a clinical diagnosis of bilateral leukoplakia of the renal pelves.

Course of illness: During the following months the attacks of left renal colic increased in number and severity, incapacitating the patient so frequently as to constitute a threat to his economic security. Despite continuous supportive therapy his condition became progressively worse. The patient consulted other urologists, who confirmed our diagnosis and also observed bladder involvement.

His course continued downhill. He lost considerable weight (18 pounds) and suffered frequent attacks of renal colic which required repeated ureteral catheterizations for the relief of urinary obstructions. It became entirely impossible for him to pursue his gainful occupation. This rapid deterioration of his condition prompted us to seek some untried method of treatment Arbitrarily we decided to administer adrenocorticotropic hormone (ACTH).

Accordingly, the patient was re-admitted to Miami Valley Hospital on October 17, 1951, for ACTH therapy. Pre-treatment studies of blood counts, blood chemistry, and electrocardiographic tracings were essentially negative. However, the urine analyses, made on many occasions, showed albumin, in amounts varying from a "trace" to 1 plus; blood, negative to 3 plus; red blood cells, "rare" to "innumerable"; and many leucocytes.

Treatment: The patient was given ACTH intramuscularly every six hours as follows: seven doses of 10 mgs. each, five doses of 12.5 mgs. each, and five doses of 15 mgs. each.

Medication was discontinued when his urine had become microscopically clear and free of albumin, and his clinical symptoms had completely disappeared. At that time there was also marked improvement in his general physical condition.

Follow-up: Since his discharge from the hospital on October 26, 1951, he has been followed for a period of nine months. He has entirely regained his weight-loss (present weight 178 pounds), is active daily at his regular occupation, and has had no recurrences of his formerly frequent attacks of renal colic. Cystoscopic examination in July, 1952, no longer demonstrated any evidence of leukoplakia.

SUMMARY

A proven case of bilateral renal leukoplakia with bladder involvement is presented.

Diagnosis was made clinically, without the necessity for surgery.

An apparent arrest of renal leukoplakia has been effected for a nine-month period in our case.

Another use for ACTH is suggested in the treatment of renal leukoplakia.

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Prolapse Gastric Mucosa

Symptomatic medical treatment will suffice in the majority of cases of prolapsed gastric mucosa, along with reassurance to the patient that he does not have an ulcer or cancer. A bland diet and antispasmodics will prove of benefit in most cases. In some instances in which nervous tension appears to be a factor, sedation with the barbiturates is beneficial.—William Tom Arnold, M. D., Houston; *Texas State J. M.*, 48:758, Nov., 1952.

Penicillin Effects on Blood Coagulation*

LEON F. MOLDAVSKY, M. D., JAMES H. CROWLEY, M. D., and
WILLIAM B. HESSELBROCK, Ph. D.

THE investigations described herein represent an attempt to analyze the factors responsible for the decrease in coagulation time following penicillin administration.[1] The immediately apparent approaches to this problem were (1) to determine the constancy and extent of this phenomenon, (2) to analyze the possible alterations in the normal clotting mechanism which might serve to explain the depression of clotting time, and (3) to determine the effects of penicillin on blood coagulation, *in vitro*.

As will become evident, the clotting response elicited by penicillin is involved in what is deemed to be a basic physiologic activity of the spleen.

The Authors

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● Dr. Crowley, St. Paul, Minn., is director of anesthesia, St. Joseph's Hospital; anesthesia consultant at St. Luke's and St. John's Hospitals, St. Paul.

● Dr. Hesselbrock, Dallas, Texas, bacteriologist, is chief of the clinical laboratory section, Veterans Hospital, Dallas; clinical associate professor of pathology, Southwestern Medical School of the University of Texas.

METHODS

These studies were carried out on volunteer human subjects who were either under treatment with penicillin or who were "normal" controls. To each patient was given a single dose of penicillin intramuscularly, and blood samples were drawn at 15 minute intervals thereafter.

The following factors were determined:

1. Coagulation Time (Lee and White)
2. Prothrombin Time (1. Quick—using Maltrine Thromboplastin, 2. Howells—Recalcification Method)
3. Bleeding Time (Ivy)
4. Clot Retraction Time (McFarlane)
5. Platelet Count (1. Rees and Echer, Modified, direct, 2. Sanford modification of Rees and Echer)
6. Assay of Plasma Anti-coagulant and Total Anti-coagulant (**Quick)
7. Hemoglobin (Sahli)
8. Red Blood Cell and White Blood Cell Counts (Standard)
9. Serum Calcium (Clark-Collip Modification of the Kramer-Tisdall Method)
10. Plasma Fibrinogen (Gradwohl)
11. Sedimentation Rate (Wintrobe)
12. Hematocrit (Wintrobe)

RESULTS

A. Constancy of the Effect.

The coagulation time in individuals of apparent health is constantly decreased after the administration of penicillin. This alteration in clotting time bears a specific, constant relationship to the concentration of penicillin in the blood. A definite time lag between the maximum penicillin blood level attained and the maximum diminution in coagulation time is further evident.

In experiments in which single doses of 25,000 units and 75,000 units are employed, the quantitative depression in clotting time produced is not different from that of the standard dosage of 50,000 units. However, the time-duration of the depression is directly proportional to the amount of penicillin given and the blood concentration obtained. This, then is in the nature of an all or none phenomenon varying only in the duration of its existence, and that of the presence of penicillin in the blood in effective levels.

B. Effect on Clotting Mechanism.

Extensive studies of the blood obtained at fifteen minute intervals after intramuscular injection of a single dose of 50,000 units of penicillin revealed no changes in the hemoglobin, red blood cell count, white blood cell count, the sedimentation rate, and hematocrit.

In addition those elements associated with coagulation, plasma fibrinogen and serum calcium and prothrombin also remained unaffected by the presence of penicillin in the blood.

In direct contrast, the number of platelets in the circulating blood during this period increased although the total number of platelets present stayed within normal limits. With this increase in platelet number, the plasma thromboplastin, as evidenced by suppression of plasma anticoagulant effect, also increased. When all plasma coagulant is mobilized by addition of an excess of heparin, the amount of thrombin required to

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* The experimental evidence presented was accumulated during the period of the author's tour of duty (1944-45) at the Harmon General Hospital, Longview, Texas; Col. G. V. Emerson, Commanding. For his gracious permission to conduct this work, appreciation was expressed.

**The Thrombin used in the Quick Assay is a Parke-Davis Product.

The Heparin employed is a Lederle Product.

produce coagulation decreases as platelet count increases.

Further, this platelet alteration is not simply quantitative but also qualitative. The size and maturity of the platelet is increased, there is greater fragility, and finally a more pronounced tendency to aggregate and agglutinate.

This definitive relation between platelet count and clotting time was emphasized by the findings. In a patient with prolonged initial clotting time and bleeding time, the initial platelet count was correspondingly low, its quantitative increase with penicillin less, and the alteration in clotting and bleeding time relatively slight; the whole effect was of transitory nature.

As a final qualitative check, the extent of clot retraction following penicillin was measured. As the clotting time shortened and the platelet count increased the influence of penicillin, so the percentage of clot retraction became greater. The increased firmness of the clot so produced lends weight to the suggestion of Tocantins[2] that the production of firm clots may be the most important role of platelets in the clotting mechanism.

C. The Role of the Spleen.

It is known that the spleen is associated with platelet level maintenance; therefore the fortuitous availability of splenectomized patients (war wounds) led to further analysis of this relationship as affected by penicillin.

To accomplish this, parallel experiments were conducted in normal and splenectomized individuals in which all the factors, clotting time, bleeding time, platelet count and plasma anti-coagulant were studied. The results showed complete abolition of the effects of penicillin on these factors, when the spleen was absent.

D. In Vitro Studies.

A number of test tube experiments were set up in which heparin controlled blood containing increasing amounts of penicillin was used. It was found that as the concentration of penicillin increased the amount of thrombin required to produce coagulation also increased. In the test tube, then, penicillin is an anti-coagulant, in complete contrast to its effect in the body.

DISCUSSION

Penicillin, then, when administered intramuscularly, is capable of reducing the clotting time appreciably, constantly and maximally for a time period determined by its concentration in the blood.

To the extent that these studies have been pursued, the only changes in the blood demonstrable was the definite elevation in platelet count as well as a qualitative alteration in the type of platelet seen. After the administration of penicillin large, mature platelets, many of them undergoing dissolution, and many forming large clumped masses appear in the blood. As is expected an accompanying increase in thromboplastic substance occurs. This phenomenon is indicated indirectly in these experiments by the demonstration of a decrease in the anti-coagulant effect.

The abolition of this clotting time depression phenomenon in those patients without a spleen signifies that penicillin must mediate its effect either directly or indirectly by stimulation of this organ. There is great similarity between the effects of penicillin and that described by Olef[3] for epinephrine. Epinephrine is capable of emptying the blood reservoirs of the spleen and producing as a result an increase in the numbers of large platelets.

If, in these experiments, penicillin stimulated the spleen indirectly by increasing adrenalin secretion, the rise in blood adrenalin was not sufficient to alter the blood pressure or pulse rate.

The startling finding that in the test tube penicillin is an anti-coagulant would seem to throw the explanation for its coagulant effect in the body even more completely on the activity of the spleen. With the administration of penicillin it must be the stimulated spleen which, by emptying itself and throwing into the blood stream immature large platelets, is able to liberate thromboplastin in sufficient quantity to swing the delicately balanced coagulation and anti-coagulation mechanisms in the direction of increased coagulation. That this stimulation occurs within physiologic ranges is shown by the fact that the increase in platelets in each specific experimental instance did not go beyond the normal range.

A more exacting analysis of the mechanisms involved in the penicillin-splenic cycle seems desirable. Plans for such an analysis through animal experimentation have been made and are to be carried out.

Addendum: Since publication of our first paper, and the completion of the work presented in this article; we have been gratified to read Macht's[4] confirmation of our original observations, on the coagulative effects of penicillin.

In a letter to the Editor of the Journal of the American Medical Association, Dr. Mort Pelz[5] of St. Louis has indicated the successful clinical application in the past two years of this coagulation effect in otolaryngologic surgery.

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Treatment of Surgical Shock

For shock caused by burns, plasma transfusions are better than blood transfusions. The reason is that such shock is accompanied by a hemo-concentration due to loss of plasma from the capillaries. This condition is the so-called "white hemorrhage" to distinguish it from "red hemorrhage" which is the loss of whole blood either outside the body or within the body cavities.—Arkell M. Vaughn, M. D., *Illinois M. J.*, 102:297, Nov., 1952.

The Acne Problem

ROY L. KILE, M.D.

The Author

● Dr. Kile, Cincinnati, Ohio, is a staff member at Cincinnati General, Christ, Good Samaritan, and Children's Hospitals; assistant professor in dermatology and syphilology, University of Cincinnati College of Medicine.

ONE of the commonest of all diseases is acne vulgaris. In fact, a few comedones during adolescence might be called a normal physiological process. Variations of this, all the way to a severe cystic acne with scarring, and extensive involvement of the upper half of the body, may occur. The statement that individuals will outgrow the disease is often fallacious. We sometimes see patients in their twenties and even thirties who are troubled with acne for the first time.

The two main criteria for active treatment of acne are: (1) Will it leave scars? (2) What effect does it have on the psychiatric makeup of the individual? Adolescents have many problems in adjustment. Adding acne to these is often most distressing for them. A recent patient was so upset by her acne that she very reluctantly would be seen in public, and had to be forced to go to school. Active and effective treatment made her a most grateful person. To belittle her symptoms would have been pathetic, for one of her parents had already added to her problem by doing so. As in many other places in the practice of medicine, one can easily err by passing over as trivial something that is tremendously important to the person consulting you. I believe this is often true with acne.

THE BEGINNING

The evolution of acne begins with the oily nose of the early adolescent. While occasionally an infant is seen with varying amounts of acne, it really begins with or just before the menses start. A three month old child was recently seen with a severe acne, having comedones, pustules, and residual scarring. The child was apparently healthy in every other respect. While certain pathological processes may cause this, often—as with this case—none are found.

As the sebaceous activity increases, plugging of the pilosebaceous apparatus occurs and comedones result. These are the primary lesions. Papules, pustules, and cysts develop from these. We are all familiar with the flare that occurs in many women preceding the menses. In fact, this occurs in older women who otherwise do not have acne. The disease must basically be some endocrine imbalance. For instance, eunuchs never get acne, but given androgen, comedones will often start to develop. These and many other observations point to the endocrine system as the internal cause of acne. True, secondary infection is common, and the acne bacillus can be found in cystic lesions, but their role must be a secondary one.

Submitted September 26, 1952.

The endocrine approach from the standpoint of therapy has not been too satisfactory. I believe this is due to the huge gaps in our knowledge of the endocrine physiology. Probably the alterations are small in degree. Much has been written regarding the endocrine therapy of acne. Anterior pituitary-like substances have been tried by many, but the results in my experience have been poor. Estrogens have been used in both male and female patients. For the latter, a mixture of steroids such as premarin® has been used during the post-ovulatory phase of the menstrual cycle. There is much less disturbance of the rhythm of menses using it during the post-ovulatory phase of the cycle. The results have been fair.

It is exceedingly difficult to appraise any one therapeutic agent in acne inasmuch as the disease is often a cyclic one with exacerbations and remissions. However, estrogen therapy by this method has offered the best internal approach in our present state of knowledge. Thyroid therapy, even in those in whom it is clinically indicated, has been disappointing in the hands of the author.

Topical estrogen therapy has been recommended. Lotions and ointments have been used. Results of such treatment in a few cases have certainly not been impressive.

MEDICATED SOAPS

Medicated soaps are not of much value other than their drying effect. Salicylic acid or sulfur soaps are available, but a pumice containing soap such as Lava® can be used. Some of the synthetic detergents in bar form are also available for this purpose.

Actually, superficial x-ray when properly used still offers the most beneficial form of therapy for decreasing sebaceous secretion and clearing up acne. Eventually the endocrine approach will

probably be the answer to the control of acne when our knowledge is sufficient to control the imbalance that undoubtedly occurs.

DIET

Dietary restriction in those with acne has been grossly overrated. Many physicians, including some dermatologists, still restrict fat intake as well as many other specific foods. The author has seen teenagers lose 10 to 20 pounds on such a diet. There is no scientific evidence that this is of any value. Actually, mice placed on a fat-free diet often develop a marked increase in skin oiliness. Ingested fat does not make the skin more oily and probably the reverse is also true.

A few foods are eliminated because flares of acne are commonly seen after their ingestion—and this is not true in all cases. However, chocolate in all forms, as well as cola drinks, are best eliminated. Fish and nuts may also be restricted. The former, when of ocean origin, have a high iodine content which may be a factor. Certain nuts seem to aggravate some patients with acne. Hence, dietary restriction, other than the few foods mentioned, is of less importance in the care of acne patients than has been generally believed.

Antibiotic therapy for very pyogenic types is most useful. If prolonged therapy is given, even in small doses, it seems to help the recurrence of the pyogenic phases. Vaccine therapy also seems to help the secondary infection. Squibb's ambotoxoid is very valuable for this purpose.

TOPICAL THERAPY

There has been little advance in recent years in topical therapy. Medicated cosmetic preparations such as acnomel® and sulforcin® base are more pleasant to use for the female, but certainly aren't a cure-all by any means. They are no more effective than some of the older sulfur preparations, but do temporarily cover up the lesions and can be used in the daytime. Sulfur, salicylic acid, or resorcin in various combinations can be used in a lotion or drying ointment base in the evening. There are also other sulfur containing preparations that can be used in the daytime so they do not show. Some of these are intraderm® sulfur, sulforcin® lotion, or dermasulf.®

Obviously, this isn't an all inclusive summary of the problem of acne, but merely points out some of the salient factors of a common disease. Acne should be regarded as important for many individuals. To them it often is a tremendous problem. While chronic and stubborn, there is still much that can be done to dry up the skin, clear up the lesions, and produce a cure in many cases. We should lend a sympathetic ear to the teenager who is confused by this problem.

KEEPING UP WITH MEDICINE

• MANUEL GARDBERG, of New Orleans, insists: "Paroxysmal attacks of pain occurring in the upper half of the body, which in every attack begin in the same area and which in every attack progress in stages to other areas which also are always the same and are in every attack reached in the same order, are almost certainly due to coronary insufficiency, regardless of how 'atypical' in location these attacks may be."

* * *

• ASIDE from being a novel and refreshing way to get fluids, watermelons are of no proven value in the treatment of the nephrotic syndrome.

* * *

• THE first six years which are the training period and the points of conflict, are often thought by the parents to be problems but are actually normal developmental patterns of behavior. It is the physician's task to treat the parents—not the child.

* * *

• HUCKSTERS filled such magazines as *Collier's, Woman's Home Companion, Cosmopolitan,* and *Reader's Digest,* with articles a year ago lauding dormison® to the skies as a hypnotic. Now we are beginning to get reports of its toxicity. The first case was one of acute exfoliative dermatitis.

* * *

• OVERNUTRITION may have some connection with the beginnings of a cancer but certainly not with its treatment.

* * *

• THE BENEFITS to mankind from a greater knowledge of soil microbiology is just becoming apparent.

* * *

• THE DISCOVERY of a method of making urea has had and will continue to have a far wider reaching influence on the lives of men than the influence of a knowledge of atomic energy will ever have.

* * *

• BOREK has recently illustrated the power of enzymes by pointing out that one ounce of rennet will clot 2,800,000 quarts of milk.

* * *

• NUTRITIONAL UTOPIA will not be reached by legislation. Its only chance is by demonstration and education.

* * *

• A CELL is a small but very complex thing and one little tiny vitamin cannot be a cure-all for its bad functioning.

* * *

• BUT FEW patients have ever shown an immediate, "wheal-like" reaction to skin tests with extracts of fungi and the corresponding reagins and in them skin testing has been known to bring on asthma.—J. F.

Procedures for Treatment of Venereal Disease

FRED O. HENKER, III, M. D.

WITH the development of prolonged action types of penicillin, very convenient therapeutic regimes became possible in which the interval between injections could be prolonged up to 4 days and the number of such injections limited to three, or even less, with adequate therapeutic blood levels maintained for a period of 8 days. The sulfa group of drugs and the newer orally administered antibiotics have also done much to render the treatment of venereal diseases less distasteful to both patient and medical workers.

The two most common venereal diseases, gonorrhea and syphilis, may be treated effectively with appropriate dosages of penicillin. Uncomplicated gonococcal infections usually respond to one injection of 2 cc. (600,000 units) procaine penicillin G in oil with 2 per cent aluminum monostearate. If the discharge persists for three days or more after the initial injection, the patient should receive 1,200,000 additional units penicillin either in one injection or two daily injections of 600,000 units. Complications will require special individual consideration.

The Author

● Dr. Henker, Columbus, is venereal disease control officer, Ohio Department of Health.

ACCEPTABLE TREATMENT ROUTINES

For uncomplicated primary, secondary and latent syphilis there are many acceptable treatment routines but recent observations have shown that procaine penicillin G in oil with 2 per cent aluminum monostearate in a total dosage of 4,800,000 units is therapeutically and economically satisfactory. This may be administered according to any of the following schedules.

VARIOUS DOSAGE SCHEDULES

(1) 2,400,000 units (8 cc. of 300,000 units per cc.) on first visit; 1,200,000 units after 3 or 4 days; third injection 1,200,000 units after 3 or 4 more days.

(2) 600,000 units (2 cc. of 300,000 units per cc.) each day for eight days.

(3) 1,200,000 units (4 cc. of 300,000 units per cc.) every 2 or 3 days for four injections.

(4) Two injections of 2,400,000 units at one treatment.

Penicillin products offering higher concentrations per cubic centimeter are being investigated but at the present time are not available for distribution by the health departments. It is now generally accepted on the basis of extensive clinical study, that the concomitant or subsequent use of heavy metal seems to be unnecessary and even to impose extra hazards.

Schedule Number 1 has proven convenient and offers some advantages over the others. The first treatment of 2,400,000 units of penicillin will render syphilis non-infectious. Continuation of therapy should, of course, be urged, but if contact is lost after one visit, the patient is not a serious health problem. If the patient returns for the other two treatments, time for education and contact interviews is afforded.

Patients with central nervous system syphilis usually respond to a total dosage of 6 to 10 million units of penicillin given over a period of 10 to 18 days. Penicillin is favorably tolerated in cardiovascular syphilis even without conventional heavy metal "preparation." Patients exhibiting evidence of circulatory failure should be hospitalized and adjunctive medication instituted during penicillin therapy. Other complications will probably require individual consideration. In the event of treatment failure or relapse as determined by failure of follow-up serologic tests to reach negativity within one year after treatment or by a four fold rise in titre following an initial drop, re-treatment with twice the originally administered dosage of penicillin is indicated.

Injection of 8 cc. repository penicillin at one site is possible without excessive pain or danger if injection is made deep into muscle tissue and the usual precaution against injecting into blood vessels is exercised. The total volume of penicillin for one treatment may be divided between two or more injection sites if it is desired to avoid large injections.

ADDITION OF CORTISONE THERAPY

For infants with congenital or other acquired syphilis, the total dosage may be calculated on the basis of 90,000 units penicillin per pound of body weight up to 4,800,000 units. This may be given in daily injections of 150,000 units until the dosage calculated has been administered. Larger children and adults with congenital syphilis should be treated with the same schedules as for comparable manifestations of acquired syphilis.

Submitted September 19, 1952.

In interstitial keratitis cortisone therapy should be added to the schedule. One drop of 2.5 per cent ophthalmic suspension of cortisone placed in the conjunctival sac hourly during the day and every two hours during the night for two days improves most cases dramatically. If a favorable response is obtained, the dosage may be reduced to one drop every four hours until treatment is completed.

ORAL MEDICATION

Chancroid can be treated with 1 gram of sulfadiazine by mouth 4 times daily for 8 to 12 days. Sulfadiazine is also the drug of choice for lymphogranuloma venereum in a dosage of 1 gram 4 times daily for 12 to 15 days. Refractory cases of chancroid and lymphogranuloma venereum are usually controlled by aureomycin, chloramphenicol, or terramycin in a dosage of 1 gram by mouth three times a day for a period of 8 days or more, determined by progress of healing. In cases of granuloma inguinale, streptomycin, aureomycin, chloramphenicol and terramycin have all been found effective. Streptomycin or dihydrostreptomycin as drugs of choice should be injected intramuscularly in doses of 1 gram three times a day for 7 to 10 days. Outpatient treatment is possible with the other three drugs when given orally in one gram doses three times a day for 7 to 10 days.

ESSENTIALITIES OF CONTROL PROGRAM

It must be remembered that the mere administration of medication does not constitute adequate treatment of a case of venereal disease. An effective venereal disease control program should embody the following objectives: 1. Diagnosis and evaluation. 2. Treatment. 3. Epidemiological investigation. 4. Follow-up. 5. Dissemination of venereal disease information. 6. Records and statistical evaluation. Each of these is essential and neglect of one can seriously weaken the entire program.

Diagnosis and evaluation of every venereal disease suspect is a tedious procedure and requires a careful and tactful history, a meticulous physical examination and judicious use of laboratory facilities. If at all possible, examination of syphilis patients should include a roentgenological visualization of the chest and a complete spinal fluid examination. Intradermal tests for chancroid and lymphogranuloma venereum can be performed conveniently in any clinic or office.

Readily available from any medical laboratory are qualitative and quantitative serological tests for syphilis and lymphogranuloma venereum, determinations of total protein and globulin on spinal fluid, smear and culture examinations for gonococci, examination of smears for H. ducreyi in chancroid and Donovan bodies in granuloma inguinale. Darkfield examinations for treponema pallidum are available in most localities, or serum from the suspicious lesion may be sent to the laboratory in special containers for delayed darkfield examination.

FALSE POSITIVE REACTIONS

Due to the fact that the serologic tests for syphilis now in use are not completely specific it must be borne in mind that false positive reactions frequently occur due to such conditions as: malaria, infectious mononucleosis, tuberculosis and other acute febrile illnesses. It is also true that many adequately treated, inactive syphilitic cases continue to show a positive serologic test for syphilis, i.e., are sero-fast. For these reasons history and physical examinations must be considered closely in handling suspected syphilis. It is wise to obtain both a flocculation type (Kline or V. D. R. L.) and a complement-fixation type (Kolmer-Wassermann) blood test with a quantitative report for the diagnosis of syphilis.

Serologic diagnosis of congenital syphilis is not reliable from a cord blood specimen since this test merely reflects the condition of the maternal circulation. Within two months after birth, the serologic picture has become that of the infant; thus a patient showing a positive cord blood test for syphilis may revert to negative within a few weeks, or vice versa. Unless history of an inadequately treated syphilitic mother, positive darkfield or physical findings indicate otherwise, a diagnosis of congenital syphilis should be withheld until checked by a serologic test for syphilis on a blood specimen obtained two months after birth.

TREATMENT ON OUTPATIENT BASIS

Treatment of all veneral diseases is possible on an outpatient basis except in cases with severe complications. In keeping with this policy the Rapid Treatment Center operated by the Ohio Department of Health since March, 1946, has been closed. No patients were accepted after April 29, 1952, and all operations were discontinued with completion of treatment on the last patient May 9, 1952. Records and follow-up data will be continued active by the Venereal Disease Control Unit during the transition period from a central rapid treatment facility to treatment by local agencies, following which such records will be returned to the local areas for ultimate disposition. Correspondence relative to former Central Ohio Rapid Treatment Center patients should be addressed to Venereal Disease Control Officer, Ohio Department of Health, Columbus 15, Ohio.

SPECIFIC CASE FINDING

From the epidemiology of venereal diseases, i.e., spread only by intimate physical contact, it is evident that for every case there must be at least one more. By questioning each patient carefully and tactfully, information relative to these contacts can be elicited. Persons named should then be located and convinced of the need for medical observation. In addition, there are

vast numbers of people unknowingly harboring venereal diseases. These must be detected by such measures as premarital and prenatal physical examinations, employment physical examinations and by specific case finding campaigns wherein certain potentially high incidence areas are screened for venereal disease.

SEROLOGIC FOLLOW-UP

Follow-up of patients treated for venereal disease is an indispensable sequel to treatment. Through this medium, treatment failures, reinfections and undiagnosed concurrent infections not controlled by previous treatment may be detected. Syphilis patients should be warned that a serological test for syphilis of their blood will probably be positive for a variable period after treatment. Completeness of cure can be determined by periodic quantitative tests for syphilis; preferably every month for one year, every 3 months for the next year, every 6 months up to 5 years after treatment and then yearly for the duration of lifetime.

Neurosyphilis patients should receive, in addition to serologic follow-up, a spinal fluid evaluation every 6 months until a completely normal report is obtained. The spinal fluid serologic test for syphilis may remain positive for many months but syphilitic activity is not necessarily indicated. Cell count and total protein determination are the most reliable indices of activity. Abnormal cell counts are values above 5 per cubic millimeter. Abnormal total protein levels are those above 50 mg. per 100 ml. Rising values of either or both indicate need for re-treatment with twice the previously administered dosage of penicillin.

Gonorrhea patients should be observed for persistence of discharge and checked bacteriologically, if possible. Since early lesions of concurrent syphilis are occasionally obscured but not cured by anti-gonorrhea penicillin routines, these patients should be followed for at least 4 months with monthly serologic tests for syphilis. Chancroid, lymphogranuloma venereum and granuloma inguinale should be followed by periodic physical examinations for status of lesions as well as by serologic tests for possible concurrent syphilis.

EDUCATION IN PREVENTIVE MEASURES

Most patients with venereal disease would not have been infected had they understood the nature of such diseases, the possible consequences and precautionary measures for avoiding them. Treatment is inadequate if the patient is not provided with an understanding of his condition. This material must also be made available to the public in general, especially to those between their mid-teens and mid-twenties, by giving talks to organizations and appropriate high school and college classes, movies and published articles. Thus infection might be prevented by arming susceptible individuals with sufficient information to enable them to conduct themselves in such a manner as to avoid exposure.

MEDICAL RECORDS AND STATISTICS

Maintenance of records and statistical evaluation is necessary for efficient coordinated operation of the venereal disease control program. Medical records must be available for research projects and for transmission to other areas when treated patients move. Through records and statistics, workers in one area become aware of the progress and nature of operations in other areas and high incidence localities are revealed so that emphasis can be shifted appropriately. Epidemiological data involving persons in areas not accessible to those handling the original case must be transmitted in the form of records to appropriate workers. To avoid confusion and duplication of efforts, a central records unit should serve to handle material from all areas.

OHIO'S VENEREAL CONTROL PROGRAM

It would be well if every patient with a venereal disease could receive complete care from his family physician but this is not entirely possible. Many people are unable or unwilling to pay for private care and many physicians do not have the necessary time to provide all of the services mentioned. To eliminate this defect the Ohio Department of Health maintains a venereal disease control program, covering the entire state, offering assistance with any or all of the phases of venereal disease control to any physician or medical agency. This program is administered by the Division of Communicable Diseases and is under the direction of the state venereal disease control officer. Services available include: free penicillin, free laboratory service, venereal disease clinics and consultation.

FREE PENICILLIN AND LABORATORY SERVICE

Penicillin for the treatment of venereal disease in medically indigent patients is provided free to private physicians and health departments. Physicians wishing penicillin should communicate with their local health commissioner.

The Ohio Department of Health Laboratory offers free for the diagnosis of venereal disease: qualitative and quantitative serological tests for syphilis on blood and spinal fluid, total protein and globulin determinations on spinal fluid, smear and culture examinations for gonococci, examinations of smear for H. ducreyi in chancroid and Donovan bodies in granuloma inguinale and complement - fixation test for lymphogranuloma venereum.

FREE CLINICS FOR OUTPATIENT CARE

For many years venereal disease clinics have been maintained by many of Ohio's city and county health departments; however, the majority of counties have no regular clinic facilities. The Central Ohio Rapid Treatment Center formerly

cared for patients from these areas who could not obtain treatment from private physicians, but with its closing a plan had to be developed whereby adequate outpatient venereal disease care would be available within a distance convenient to every part of the state, until facilities could be evolved locally by each health jurisdiction. Agreements have been made with certain full-time clinics to accept patients from surrounding counties without charge upon receipt of proper application from the patient's physician or health department. These clinics will be referred to as Venereal Disease Prevention and Control Centers and will receive all possible assistance toward achievement of a status of eminent authority in matters pertaining to venereal disease in their respective districts.

In areas not located near prevention and control centers, similar arrangements have been made with part-time clinics which will be referred to as subsidiary clinics. In every case possible, existing facilities will be utilized as prevention and control centers or subsidiary clinics; however, in areas now inadequately served where venereal disease incidence justifies, expansion of present clinic facilities or establishment of new ones will be urged and stimulated by making available on a loan basis equipment made surplus by closing of the Central Ohio Rapid Treatment Center, furnishing all penicillin necessary for clinic use, and financial assistance where necessary.

ALL PHASES OF CONTROL AVAILABLE

Clinics participating in the plan will continue to operate unchanged except in receiving patients, without charge, referred from certain designated neighboring cities and counties in addition to those from their own areas. There will be a minimum of interference from the Ohio Department of Health. All phases of venereal disease control will be available through these clinics, including diagnosis and evaluation, treatment, venereal disease education, epidemiology, follow-up and application of a uniform record and reporting system.

Schedules and procedures remain entirely under the jurisdiction of a venereal disease clinician who is specially trained in methods of management of venereal diseases. He will be available at regularly scheduled times to administer or supervise diagnostic and evaluation procedures and treatment. A venereal disease control officer will be available on a state level to render consultation on venereal disease problems to any physician or clinic and to make periodic visits to the clinics.

THE CLINIC NURSE

Much of the responsibility of operation is borne by the clinic nurse. She should supervise or perform all functions of the prevention and control center under the guidance of the director. In many cases, the clinic nurse will have the responsibility for education and contact interviewing. District nurse consultants also will make periodic visits to the various health departments and will be available for consultation and advice in order to assist local clinic nurses solve those problems not coming directly under the jurisdiction of the clinic director. Special courses and training sessions will be made available to those nurses feeling the need for additional training in this field.

FIELD INSPECTORS

In an effort to strengthen epidemiological services provided by clinic nurses, several of the larger cities employ lay venereal disease interviewer-investigators. In addition the Ohio Department of Health has assigned a field inspector to each of the five district offices who spends 50 per cent of his time in contact interviewing and case finding when requested by those health departments in his jurisdiction. U. S. Public Health Service interviewer-investigator trainees assigned to the Ohio Department of Health are also stationed in certain congested areas showing an unusually high incidence of venereal disease. All of these workers will interview venereal disease patients in a tactful and scientific manner to obtain the names, addresses and other identifying information of all potentially infected contacts. This confidential information is to be recorded on appropriate forms and sent to a central records unit for statistical extraction and redistribution to the areas in which the contacts reside. An investigator receiving a report of a contact in his area locates the individual and institutes the necessary action to have any indicated examination and treatment performed.

Interviewer-investigator training programs will be made available from the state for workers desiring instruction and consultation in epidemiological procedure.

CLOSE COOPERATION CAN LOWER INCIDENCE

Control efforts have reduced the incidence of venereal disease noticeably in recent years but the problem is far from being completely solved. During 1951 there was reported from the State of Ohio: 7,129 new cases of syphilis, 8,126 new cases of gonorrhea and 99 new cases of other venereal diseases, a total of 15,354 cases. With close cooperation between private practitioners, their health departments, and the Ohio Department of Health, this number can be reduced to an insignificant level within a surprisingly short time.

Bronchoscopic aspiration in cases of atelectasis in children frequently leads to re-expansion of the collapsed lobe, and therefore prevents subsequent bronchiectasis.—Gans. B., Lewisham Hospital, London; *Arch. Dis. Childhood,* 27:254, June, 1952.

The Surgical Treatment of Bonchiectasis*

SPENCER W. NORTHUP, M. D.

IT is the purpose of this paper to answer the question, "Shall patients with asymptomatic bronchiectasis be subjected to surgical extirpation of involved lobes or segments?"

Bronchiectasis was first described as a clinical entity by Laënnec in 1819. Thousands of people have suffered the devastating personal and social effects of the disease, only to die of it from 20 to 30 years after its onset. It appears most frequently in the first and second decades of life, destroys the health of young people and not only renders them invalids, but makes many so socially unacceptable that employment and marriage are denied them and some are even driven to suicide.[1, 2, 3]

Adams and Ficarra[3] described the condition of these patients from personal experience of considerable scope: "There can be little doubt that a prolonged struggle against chronic disease may influence the character and career of any man. Patients with bronchiectasis often fall into this category. By the general public, these patients are branded as having tuberculosis. Oftentimes they have been studied in vain for tuberculosis; sometimes they have spent prolonged periods of time in tuberculosis sanatoriums.

"In the young, schooling is neglected because illness renders the child unable to keep pace with his classmates. With expressive but cruel wit, one child with a chronic cough was nicknamed 'The Barker' by his fellows and another with foul sputum, 'Stinky'—and they thenceforth attended school only under duress. The antisocial pattern may be more clearly defined in the late teens when social contacts are made only under the handicap of a productive cough or foul sputum. The young man may be unable to hold his job because of recurring respiratory infections or chronic fatigue. The young woman may worry about scanty menstruation or suspected personal unattractiveness.

"Marriage is frequently postponed. If entered into, lack of libido and interruption of normal marital relationships by the necessity of cough and evacuation of sputum often strains the bonds of happy marriage. The increasing responsibilities of life in the late twenties and early thirties and the decrease of recuperative powers of youth account for the large number of bronchiectatic patients who 'break down' in this age period. Thus it can be appreciated that the social, economic, mental, and physical aspects of bronchiectasis make this a subject of paramount concern."

The Author

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ETIOLOGICAL FACTORS

No doubt there are some cases of congenital bronchiectasis associated with situs inversus and chronic sinusitis (Kartagener's syndrome). However, the most common etiological factor is dilation of the bronchi due to alteration of intrapleural pressures from atelectasis of one or more segments of the lung as described by Anspach. When secretions, stagnant in the dilated bronchi, become infected, the bronchiectasis becomes clinically evident.

The disease most frequently is noted after pneumonia, whooping cough, measles, or mumps —at which time persistent dry cough, productive cough, or hemoptysis may lead to roentgen examination of the chest. Anspach has described a triangular shadow in the base of the lungs of children with bronchiectasis. He ascribed the shadow to the bronchial dilation and associated atelectasis, but did not consider that it is pathognomonic of bronchiectasis.

Chronic sinusitis is often mentioned as an etiological factor in bronchiectasis but Riggins,[2] Goodale, and Perry and King[1] showed that sinusitis is more often secondary to bronchiectasis than is it a cause, or even an important factor, in the etiology. Goodale found that of 75 patients with bronchiectasis only six had a history of sinusitis prior to the onset of bronchiectasis.

Factors other than pneumonia in the origin of bronchiectasis are described by Crandall who stated that it may be secondary to foreign bodies (especially after tonsillectomy), bronchial tumors, peribronchial pressure due to lymph nodes, mediastinal tumors; intrapulmonic factors such as tuberculosis, tumors, lung abscesses, fungus diseases, and emphysema; pleural changes such as adhesions and effusions; and secondary to changes in the thoracic wall such as scoliosis and kyphosis.

DIAGNOSIS

The diagnosis is not made until technically excellent bronchograms reveal typical saccular or cylindrical dilations of bronchi in one or more

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The opinions expressed in this paper are those of the author, and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

segments. (See figure 1-a and figure 1-b.) It is noteworthy that the dilation of bronchi is common after pneumonia, especially so-called atypical pneumonia, and that some time (6 weeks) should elapse following the disease before bronchograms are made. This dilation has been called pseudobronchiectasis by Blades and Dugan and it is transitory.

Ochsner, DeBakey and DeCamp,[4] in their analysis of 96 cases, revealed that the mean age of onset was 13 years and in 21 per cent symptoms began in the first two years of life. Bradshaw, Putney and Clerf, writing on the fate of patients with untreated bronchiectasis, reported a 10-year follow-up on 127 patients of whom 59 died. The average duration of life following the onset of the disease in those that died was 13.5 years.

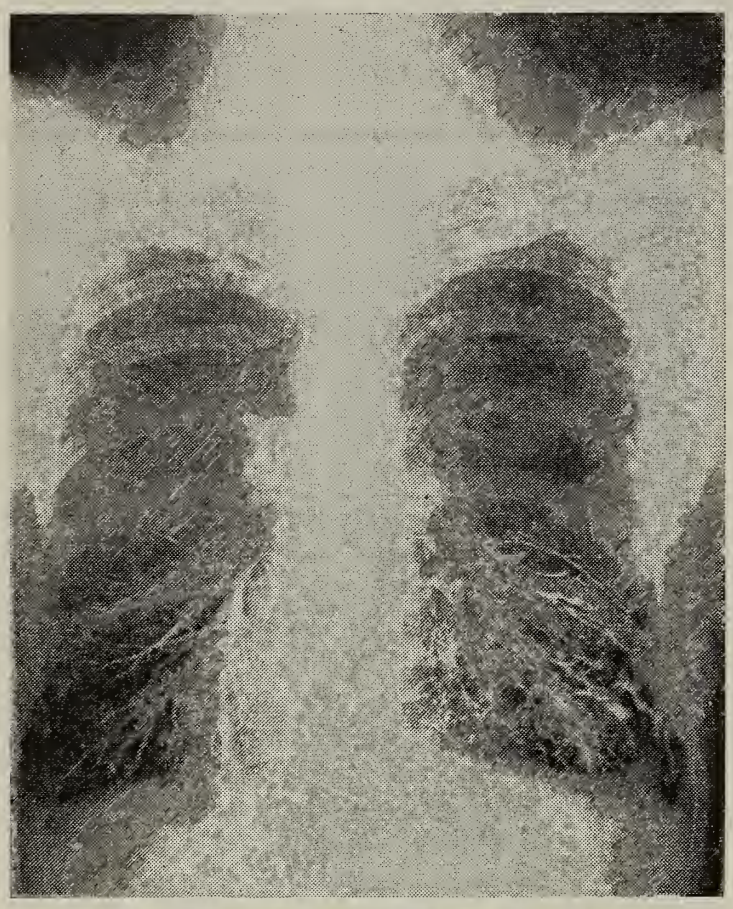


Fig. 1-a. Bronchogram, posteroanterior, showing bronchiectasis.



Fig. 1-b. Bronchogram, lateral, showing bronchiectasis.

In the development of this disease histologically, Kay, Meade and Hughes[5] stated that the ciliated columnar epithelium of the bronchi is frequently ulcerated and replaced by non-ciliated cuboidal or squamous epithelium, and the normal elastic and smooth muscle fibers are partially or completely replaced by granulation or scar tissue. Because of loss of the normal cleansing action of the bronchial tube, stasis of exudate and resulting infection occur.

Once the dilation of bronchi, with resultant infection and destruction of normal mucosa has occurred, the condition is irreversible. Many authors[1, 2, 3] agreed that the disease is progressive, but not in the sense of spreading from bronchus to bronchus or from involved segments or lobes to previously uninvolved segments. The progression consists of the response of lung parenchyma and peribronchial tissues to constant or recurring infection which results in pulmonary fibrosis, emphysema, and/or suppurative pneumonitis. These changes are directly proportional to the severity of infection. Riggins stated,[2] "Not infrequently in extensive dry bronchiectasis fibrotic changes are conspicuous by their absence to the extent that even saccular bronchiectasis might be overlooked by the roentgenogram."

COMPLICATIONS

Common complications of bronchiectasis are:

1. Atypical pneumonia—recurring;
2. Lung abscesses;
3. Cor pulmonale;
4. Brain abscess;
5. Emphysema and pneumothorax;
6. Amyloid disease;

MEDICAL THERAPY

The therapy of bronchiectasis was once medical only and aimed at promoting bronchial drainage. With the introduction of antibiotics, marked temporary improvement could be produced with a combination of antibiotic therapy and improved bronchial drainage. Postural drainage, bronchoscopic drainage, breathing and coughing exercises, and medicaments to thin viscid exudates, all aid in effecting such drainage. The eradication of foci of infection and dietetic measures improve the general condition of the patient. This is still excellent treatment but when antibiotics are discontinued, symptoms recur.

The mortality of medically treated disease is impressive, Perry and King followed 260 untreated or medically treated cases for 12 years. The mortality rate for males was 36 per cent. Mor-

tality rate when bronchiectasis was cystic was 55 per cent, saccular 37 per cent, cylindrical 13 per cent; when bilateral, 42 per cent, unilateral 25 per cent. The morbidity rate of 100 patients followed by Riggins[2] for 10 years revealed that 35 per cent were unable to work and an additional 40 per cent worked only part time.

ROENTGEN RAY THERAPY

Roentgen ray therapy of bronchiectasis first recorded by Berch in 1934 may be mentioned only to condemn it. Roentgen therapy produces radiation pneumonitis with resultant fibrosis and adhesive pleuritis and further embarrasses oxygen exchange in the lung. It was originally based on the premise that irradiation would decrease bronchial secretions, but since the normal bronchial mucosa has already been replaced by scar tissue by the disease process, roentgen therapy can do no more.

SURGICAL TREATMENT

When referring to the surgical treatment of bronchiectasis and indeed of any surgical attack on the lung, we must distinguish between cases operated upon since the introduction of the individual ligation lobectomy in 1942 and those operations done by the mass tourniquet technic prior to 1942.

Before 1942 all authorities agreed that surgery offered the only hope of cure in bronchiectasis, but many were reluctant to recommend surgery because of the impressive mortality rate. Ochsner, DeBakey and DeCamp[4] reported 13 tourniquet resections with six deaths. Ninety-two resections by the individual ligation technic with no deaths were reported by the same group.

Lyman Brewer III reported 60 lobectomies with no death;[3] Lindskog and Alley, no mortality in 33 resections in 20 patients with bilateral disease;[6] Buckles, no mortality in 28 resections on 25 children; and Potts, no mortality in 1 pneumonectomy, 6 segmental resections, and 9 lobectomies in children. Kay, Meade, and Hughes reported 1 death in 220 lobectomies.[5]

The individual ligation technic offers the bronchiectatic patient safe surgery, permits the resection of lobes or segments alone so that all possible uninvolved lung tissue can be spared. It has made resection for bilateral disease a feasible procedure.

Resection, which was once limited to unilateral disease in young people, has thus been extended to the older age group and to those with multiple lobar disease. Surgical resection not only removes the disease process but in removing involved lobes it improves the oxygen exchange. Bronchiectasis may block respiratory passages, produce fibrosis and pneumonia, but it does not destroy the pulmonary blood supply to involved lobes. Therefore, venous blood passing through these lobes fails to be oxygenated. Removal of the diseased lobes shunts the blood to lung tissue capable of aerating it and increases the efficiency of respiration.

Since bronchiectasis is such a devasting chronic progressive disease and since a safe cure is available, one might suppose that all such patients should be operated upon. Undoubtedly the mortality for resection has remained low because of the caution with which thoracic surgeons have approached resection in bronchiectasis and especially resection in bilateral disease. With the advances in surgical technic, antibiotics, and improved anesthesia the boundaries of feasible resection have been pushed back markedly.

CONTRAINDICATIONS

However, there are still some classes of patients in whom surgical intervention is contraindicated, namely, those whose physical condition is such that any major surgical procedure would be contraindicated and those in whom the bronchiectasis is so widespread that removal of all of the disease is impossible. To them Ochsner would add, ". . . provided the disease is not too mild or the patient too elderly."[4]

In the opinion of most authors resection is contraindicated in children who are asymptomatic. These patients may have pseudo-bronchiectasis, or if true bronchiectasis it is cylindrical and dry, and no peribronchial inflammatory reactions are occurring. Most of these patients eventually become symptomatic, however. Fine and Steinhausen[7] reported on 156,000 routine roentgenograms of the chest, which revealed 638 men with nontuberculous infiltration. Bronchograms revealed 41 of these to have bronchiectasis. In a 2-year follow-up of 36 of these previously asymptomatic soldiers, 1 was dead from empyema, 2 had had lobectomies, 8 still had no symptoms; 25 had symptoms of whom 12 had slight ones, 8 moderate, and 5 severe. Of the 36 patients, 4 had hemoptysis; 25 had cough; and 25 excessive sputum.

Since it is evident that asymptomatic disease eventually becomes symptomatic, it is good medical practice to wait until the patient's symptomatology indicates the necessity for bronchograms which can carefully delineate the bounds of the disease. At this time only should operation be undertaken to remove all involved segments.

The only valid argument favoring resection of bronchiectatic lobes in asymptomatic patients is that of Adrian Lambert who stated that the mortality is almost twice as great in the operated group whose bronchiectasis is complicated by acute suppuration than in the group without suppurative disease. Personal experience has shown that the preoperative preparation of the patient by repeated bronchoscopic drainage and nebulized instillation of penicillin and streptomycin solutions will temporarily control suppurative disease. The schedule of antibiotic

treatment is crystalline penicillin, 40,000 units per cc., 2 cc. to be inhaled at each treatment, plus 125 mg. of streptomycin per cc., 1 cc. being inhaled at each dose. These are given by nebulizer four times a day for 4 days preceding surgery. In addition 300,000 units daily of procaine penicillin are given, beginning 48 hours prior to operation.

CONCLUSIONS

Following surgical intervention, experience has shown that previously bronchiectatic patients must take measures to maintain excellent physical condition and avoid repeated upper and lower respiratory infections.

Bronchiectasis is a surgical disease except in those cases in which the disease is too mild to warrant operation, too extensive to permit resection, or in patients too ill to withstand a major surgical procedure.

SUMMARY

The experience of leading thoracic surgeons in the past 15 years is presented, to reveal that with the advent of the individual ligation method of lobectomy, surgery has become the treatment of choice in most cases of bronchiectasis. Medical treatment is most important in preparing these patients for operation.

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Effects of Smoking on the Heart

Decisions regarding smoking by patients with coronary artery disease are always difficult. There is no unanimity of opinion among various investigators in this field. There is some evidence that smoking has no effects in patients with heart disease which are significantly different from those in persons with normal hearts. However, if there is any suggestion from the clinical history that the patient has more distress during or after smoking, I believe he should give it up.

Occasionally a patient will be encountered who will have significant electrocardiographic abnormalities demonstrable during smoking, even though there is no cardiac pain at the same time. Such patients are a minority, but they should stop smoking completely. The advice of the physician to the cardiac patient regarding smoking must be individualized, but actually it is my experience that the majority of patients will not follow the doctor's recommendations.—Francis F. Rosenbaum, M. D., Milwaukee; *Wisconsin Med. J.*, 51:990, October, 1952.

The Evaluation of Hypertension

If the definition of the normal range of blood pressure is to be modified, it should be appreciated that this is applicable mainly in the older age group. The significance of "borderline" blood pressure levels in young men remains to be fully appraised. This refers to those readings a little over 150 systolic and 90 diastolic when they occur transiently at the beginning of an examination and subside on quiet rest for one-half hour.

A follow-up study on cardiovascular rejectees for military service by White, et al., revealed that of 67 men among the total of 303 who showed transient hypertension in 1943, 33 had normal blood pressure in 1947, 17 still showed transient hypertension, and 17 were found to have sustained hypertension. The correlation with increased weight in this group was not conclusive and the authors stated that longer follow-up would be necessary.

But to the industrial physician, the finding of increased weight and transient hypertension in pre-employment examination of young men should suggest that this combination in a certain percentage may lead to increased incidence of hypertensive vascular disease. In this type of case the necessity of weight reduction as a preventive medical measure is obvious.—S. Charles Franco, M. D., New York City; *Industrial Med. & Surg.*, 21:522, November, 1952.

The Clinical Use of Resins

There are certain precautions which should be taken preparatory to starting a patient on cation exchange resin therapy. The blood nonprotein nitrogen should be determined, and some workers state that if it is found to be elevated, resin therapy is definitely contraindicated, since there is a strong possibility that the renal sufficiency will be aggravated. I do not personally feel that this should always rule out the use of resins but admit that one must proceed cautiously in such cases.

A baseline electrocardiogram should be done for future reference in looking for hypopotassemia. The patient should be weighed daily early in the course of therapy, and should maintain a fair appetite and reasonably good urine flow. If edema is present, slight to moderate diuresis should occur within three days, followed by more marked diuresis if a mercurial is then used. If this does not occur, renal failure or low salt syndrome should be suspected.

Hyperpnea, nausea and vomiting, weakness, cramps, or drowsiness should lead one to stop resin therapy, check the chloride, carbon dioxide and nonprotein nitrogen levels, and repeat the electrocardiogram. Sodium and potassium levels should also be determined if possible. —Woodrow Batten, M. D., Smithfield; *North Carolina M. J.*, 13:611, November, 1952.

Chronic Extradural Hemorrhage—Report of Two Cases

WILLIAM R. CHAMBERS, M. D.

EXTRADURAL hemorrhages are relatively rare. According to Rowbotham[1] they are found only in about 3 per cent of cases in any large series of acute cerebral trauma. Furthermore, they are almost always mentioned as acute episodes, and chronic epidural hematomas are so rare as to make a report of them of some interest. Munro,[2] Moody,[3] Gurdjian and Webster,[4] and Jackson and Speakman,[5] among others, have reported cases, the longest interval being 36 days between trauma and operation.

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CASE REPORTS

Case One: The patient, a white male in his fifties, was found lying on his garage floor, as if in deep sleep, and could not be aroused. Two weeks previously, his car had slipped off a jack and struck his head.

When taken to the hospital he roused enough to answer a few questions, but soon became disoriented and belligerent. He denied taking any sedative. He soon slipped into coma.

On examination, the pupils were equal, contracted, and reacted to light. There was slight rigidity of the neck. The deep tendon reflexes were abnormally brisk, but approximately equal; the abdominal reflexes were present and equal; Babinski reflex, present bilaterally. The blood pressure was 110/80, pulse 112, and respirations 24. Spinal puncture revealed a pressure of 286 mm. of water with 66 mg. per 100 cc. protein, no white blood cells, 2630 red blood cells, and the Wassermann test negative.

Operation: Craniotomy revealed a large extradural hematoma on the left extending from the midfrontal region to the occipital pole. It was firmly adherent to the dura, and partially organized.

The patient made an uneventful recovery.

The head injury in Case One was well known, and the interval from injury to operation was slightly more than two weeks. In Case Two the history was quite different.

Case Two: The patient, a young housewife in her twenties, began gradually to have headache, meningismus, vomiting, and fever up to 101.2° F. She was taken to her local hospital where her spinal fluid was shown to contain 1000 white blood cells per cu. mm. with 70 per cent polymorphonuclear leukocytes. The protein was 150 mg. per 100 cc. and the sugar 50 mg. There was no history of head injury or acute infectious process. Cultures of the spinal fluid were negative. She showed a good response to penicillin, and after two weeks was discharged.

Within a short time she was re-admitted because of drowsiness, listlessness, headache and meningismus. There was now some slight blurring of the disc edges. The cell count of the spinal fluid was now 5000, with 100 per cent polymorphonuclear leukocytes. Again cultures, smears, and virus studies were negative. A brain abscess was suspected, and neurosurgical consultation called.

A ventriculogram showed displacement of the whole ventricular system to the right. A carotid angiogram confirmed this finding. No fracture was seen. The cells of the spinal fluid at this time were 450 per cu. mm., with 44 per cent polymorphonuclear leukocytes.

Operation: Craniotomy some six weeks after onset revealed a large chronic extradural hematoma, tough and organized, covering the whole parietal lobe, and extending over some of the occipital area. It was about 1-inch thick. There was no evidence of infection.

The patient, who had been very slow mentally, and disoriented previous to operation, now made rapid and full recovery.

DISCUSSION

While cultures were always negative, and no evidence of infection was seen at operation, at least an original hidden infection must be supposed from the pleocytosis and the early response to penicillin. Merritt and Sciarra[6] state that, in cerebral trauma, a moderate or marked pleocytosis of the spinal fluid may occur within a week after injury. On the other hand, they state just below this that in extradural hematoma the fluid is entirely normal, unless there is a concomitant contusion or laceration of the brain.

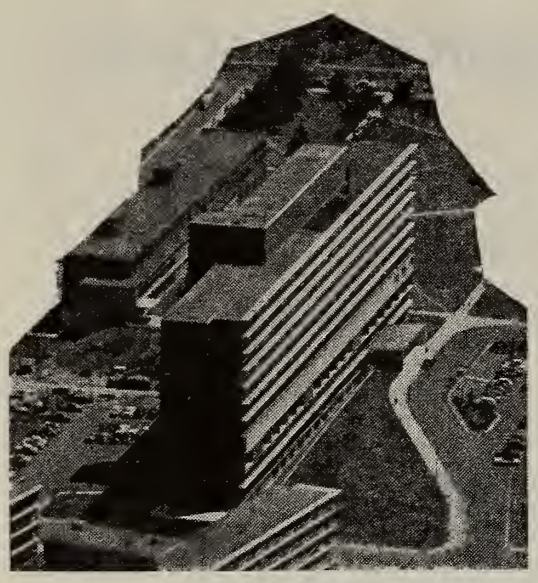
Schneider and Hegarty[7] have reported two cases of extradural hemorrhage as a complication of ear and nasal sinus disease.

In our case, conscientious search was made for a focus of infection without finding any. The duration of the second case from onset of symptoms to surgery was more than six weeks. If it were to be supposed that the extradural hemorrhage had existed all this time, then it would be by far the longest case on record. Unfortunately, there is no way to prove this. It was a very old, organized extradural hematoma. A paucity of neurological signs is to be noted, as reported by Schneider and Hegarty.[7]

Submitted September 9, 1952.

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A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Robert Ritterhoff, M. D., President

Presented by N. O. Rothermich, M. D., and E. von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THE patient was essentially normal until the age of 13, when he suddenly gained weight. With a height of 4 ft. 9 in., his weight rose to 190 pounds and the fat became very conspicuous over his breasts and hips. His voice did not change pitch. During the next six years he complained of occasional severe headaches. His libido was completely absent.

At 18 years of age he developed a dry scaly itching rash in the pubic region, for which he received various kinds of treatment including x-ray therapy. However, the dermatitis spread slowly over his entire body. At twenty-four years of age he began losing his scalp hair. Shortly thereafter his physician found that his blood pressure was high and placed him on a reducing diet and thyroid extract. Under this regime he lost over 70 lbs. With this weight loss he noted generalized weakness, which slowly progressed. He was referred to University Hospital for further diagnostic studies and treatment.

Physical examination revealed a small, feminine-appearing 25-year-old white male with a high-pitched voice and the wrinkled face of an old man. His height was 4 ft. 9 in., his weight 125 lbs. The breasts and hips were obese. The skin was dry, scaly and thick, particularly over the palms and soles. The fingernails were thickened and loose. There was a thin fine beard on the chin; there was no chest hair; the axillary, pubic and scalp hair was thin, the pubic hair feminine in distribution. There was slight exophthalmos. The thyroid was not enlarged. The penis was small and the testes atrophic. His blood pressure was 150/100.

Laboratory Findings: A glucose tolerance test showed an initial blood sugar of 85 mg. with 200 mg. in two hours, 132 mg. in three hours, and 63 mg. in four hours. The twenty-four hour urinary excretion of 17-ketosteroids was 25 mg. and 17 mg. on two determinations. The basal metabolic rate was minus 14; the protein-bound iodine A fraction was 1.3 mcg., C fraction 2.0 mcg. Sedimentation rate, total protein and A:G ratio, serum sodium, potassium, blood urea nitrogen, chlorides, cholesterol, phosphorus, van den Bergh's test, thymol turbidity, amylase, prothrombin time, alkaline phosphatase, calcium and cephalin flocculation, were all within normal limits.

X-ray films of the skull showed a normal sella turcica with no evidence of abnormal calcification or demineralization. A Thorn test showed an initial eosinophil count of 44 with a final 4½ hour count of 150. A right testicular biopsy revealed marked atrophy of the seminiferous tubules and hypoplasia of the interstitial cells. Examination of scrapings from the fingernails revealed fungi (type not stated).

The clinical diagnoses of hypothyrodism, possible hypopituitary state and neurogenic dermatitis were made and the patient was discharged on thyroid therapy.

The patient discontinued his diet and regained weight, reaching 155 lbs. He lost about 2 in. in height in about one-and-a-half years. He began to notice shortness of breath on exertion and frequent occurrence of paroxysmal nocturnal dyspnea. The headaches, which he had not experienced since the age of 17 years, returned and were much more severe and frequent. His teeth were becoming soft.

Hospital Readmission: The patient returned to the hospital about one year after his first admission. On physical examination he was somewhat dyspneic. The blood pressure was 200/190, the pulse 130. The skin exhibited the scaling dermatitis noted on the previous admission. There was an accumulation of fat in the inferior

mandibular region and around the back of the neck producing a characteristic "buffalo hump." There was slight exophthalmos and the funduscopic examination revealed a decrease in the number of retinal arteries and definite A-V nicking. The sella turcica was normal in size radiologically, with no evidence of erosion.

The urine contained 200 mg. of albumin. The erythrocyte sedimentation rate was 36 mm. in one hour. Electrolyte studies revealed a sodium level of 350 mg., potassium 11 mg., chlorides 412.5 mg. The CO_2 combining power was 66 vol., the serum phosphorus 1.94 mg., the alkaline phosphatase 12.62 units, the acid phosphatase 0.3 units. Numerous 24-hour excretion studies of the 17-ketosteroids gave results varying from 8 mg. to 88.2 mg. in 24 hours, the average excretion being 20.4 mg. for a 24-hour period.

Operation: The patient was placed on potassium chloride and testosterone. It was felt that the clinical and laboratory evidence indicated a Cushing's syndrome. On the 24th hospital day approximately 95 per cent of the left adrenal gland and 80 per cent of the right adrenal were removed. It was felt that the blood supply to the remaining left adrenal had been sufficiently injured that the remaining gland would be functionless. Microscopic sections of the gland showed changes compatible with functional hyperplasia. The pathologist estimated that about 90 per cent of the total adrenal tissue had been removed.

Postoperative Report: Immediately following surgery the patient's blood pressure fell to 105/70 and for the next two days fluctuated widely. Under Neo-Synephrine,® adrenal cortical extract and blood transfusions it was brought up to 150/100. He was then placed on Doca,® which produced an immediate response, bringing the blood pressure up to 180/130. The blood pressure was sustained at levels of 200-210/140-150, and it was discovered that the patient had received erroneously 25 mg. of Doca® instead of 5 mg. By the fifth post-operative day the patient was sitting up for extended periods; he felt stronger and ate and slept well.

During the third post-operative week he developed a perirectal abscess which drained spontaneously and cleared up under conservative management with antibiotics. The white count reached 21,350 with a differential count of 46 per cent neutrophils, 26 per cent lymphocytes and 28 per cent eosinophils. During this period his eosinophil count varied from 1,666 to 2,733. An ACTH test, done to determine adrenal cortical function, showed an initial eosinophil count of 511 and a final count at the end of four hours of 522 eosinophils. A sedated metabolic rate done a month after surgery was minus 6. The protein-bound iodine C fraction was 5.7 mcg., A fraction, 1.3 mcg.

Suddenly the patient developed in his third post-operative week extremely severe epigastric pains, which were cramping and boring in character and lasted for long periods of time. He became anorexic and nauseated and vomited frequently. His upper abdomen became very tender to palpation. Continuous gastric suction was instituted and he was given intravenous fluids. Because of the persistent severe pains a paravertebral block was done on the 66th hospital day using 20 cc. of a 1 per cent procaine on each side. Approximately twenty minutes following the procedure he suddenly cried out and became rapidly cyanotic. His blood pressure and pulse became unobtainable, his respirations were gasping. An endotracheal tube was inserted and artificial respirations with oxygen were administered; however, he expired several minutes later.

His death occurred on the 66th hospital day and 42 days following the subtotal bilateral adrenalectomy.

CLINICAL DISCUSSION

DR. N. O. ROTHERMICH: The case before you today comprises a voluminous record and time permits us to discuss only the outstanding features of the story. It is noteworthy that the patient was apparently normal and called a "skinny boy" until past 13 years of age, and there is nothing to indicate a familial tendency to obesity.

The initial variation from normal in this boy was a tremendous increase of appetite beginning at about 13½ years of age, and of course this soon resulted in an enormous weight increase. I would assume that the appetite change represents the first pathological feature of the case.

His fat distribution was limited to the trunk, especially hips, shoulders and breasts, and at the age of 15 true gynecomastia was noted. His bulging misshapen body brought on ridicule and scorn from his school mates, and this aggravated the obesity problem because, as so often happens with fat people, he sought solace and comfort in increased food intake. However, for short periods he was persuaded to go on a strict diet and at these times he would lose considerable weight and his general condition would improve.

At about the age of 17 he developed what was described as "athlete's foot," which later spread up his leg in patches and then onto his trunk and upper extremities and eventually involved virtually every square inch of skin on his body. The skin became elephantine in character with an incredible amount of desquamation, amounting to at least a washbasinful daily. In the following six to eight years his weight fluctuated widely depending on his adherence to or deviation from his diet, and he noted also spells of great weakness from time to time.

Eventually at the age of 25 he came to the outpatient clinic, where his complaints were weak-

ness, extreme obesity, and a massive scaly thickening of the skin all over the body. He was found to have an elevated blood pressure, the diastolic being consistently above 110. Because of his obesity some observers entertained the idea of a Froelich's syndrome, a not too well understood disturbance of growth and fat metabolism in adolescent boys thought to be due to a lesion of the hypothalamus.

HYPOPITUITARISM?

A tentative diagnosis of hypopituitarism was made and he was admitted to University Hospital for a complete laboratory survey. All tests were normal except the basal metabolic rate of minus 14 and a protein-bound iodine of 2 mcg. A testicular biopsy showed marked atrophy, and it is noteworthy that his urinary gonadotropins were not increased. This would strongly indicate a primary pituitary type of hypogonadism.

When the boy returned to the clinic for observation one year later his blood pressure was extremely high and his obesity was of the buffalo type with striae around the shoulder girdle and neck. He showed no beard growth, his voice was high-pitched, and his genitalia were atrophic. There was noticeable reduction in height, although it was not measured. There was no laboratory evidence of hypothyroidism and the ketosteroids in the urine were slightly elevated. At that time his blood potassium and his blood chlorides were significantly low and his blood sodium elevated. For this reason the clinical diagnosis of Cushing's syndrome was made this time.

There is a distinct difference between Cushing's disease and Cushing's syndrome. The clinical features of this condition were first described in 1932 by Cushing and thought by him to be due to a basophilic adenoma of the pituitary. This adenoma may sometimes be only microscopic in nature but its existence is considered essential for the diagnosis of Cushing's disease. In the meantime we have come to realize that most, if not all, the symptoms described by Cushing may be the result of hyperfunction of the adrenal cortex. For this reason the term "Cushing's syndrome" is reserved for patients who show the clinical features of Cushing's disease without demonstrable histological basophilic adenoma.

A YEAR BEFORE

It is remarkable that one year previously the patient was considered with some justification a case of hypopituitarism. Of course the high blood pressure always ruled out pan-hypopituitarism such as Simmonds's disease, but the genital atrophy with low titre of urinary gonadotropins, some features of his obesity, and the low basal metabolic rate fit well with such a diagnosis. The fact that there existed simultaneously in this patient evidences of reduced or absent pituitary function in certain spheres and evidence of pathologically increased pituitary function in other spheres would be a strong argument in favor of a diagnosis of a basophilic adenoma of the pituitary gland encroaching upon the other functional elements of the gland, or a true type of Cushing's disease.

Finally the diagnosis of Cushing's syndrome was agreed upon and bilateral subtotal adrenalectomy was performed. The blood pressure dropped and his skin condition cleared remarkably after the operation. He was given large amounts of desoxycorticosterone and cortisone (even toxic doses of the former), and his blood pressure returned to fairly high levels.

THE PAIN

It should be noted now that within a few weeks after the operation, apparently because of the sustained high blood pressure, all adrenal cortical substitution therapy was discontinued and never resumed thereafter. He developed a fine, mottled rash over most of his body and gave evidence of some toxicity with rise in temperature. Soon thereafter he began to have severe abdominal pain of such intensity that it could not be relieved by narcotics. The pain was more or less continuous with only short periods of relief and was accompanied by nausea and protracted vomiting.

The nature of this pain was apparently never determined clinically, and even now it is difficult for us to hazard a guess as to the cause. Pancreatitis could fairly well be ruled out by the normal blood amylase levels. This type of abdominal pain is reminiscent of that seen in acute porphyria or even in plumbism, and also is seen in the crisis of sickle cell anemia. The leukocytosis of 21,000 should not be misleading, because one may remember that diabetic patients on the brink of acidosis often complain of severe abdominal pain and may have a leukocytosis of 25,000 to 30,000, but abdominal surgery in such cases is fruitless and unwarranted.

The patient's course thereafter was progressively downhill with critically low blood pressures. Shortly before he died he was found to have a total eosinophil count of over 10,000 with a severe sodium depletion and hypochloremia and a relative increase in blood potassium.

RECAPITULATION

To recapitulate and summarize, we have before us the case of a 26 year old white male whose symptoms first began at the age of 13 years with tremendous increase in weight. He subsequently developed sustained severe hypertension, a "buffalo" type of obesity, some hirsuitism and striae purpurae, a "moon" facies, a settling and shortening of his height, and marked general weakness. He was found to have in addition to high blood pressure advanced testicular atrophy, a normal

or low urinary gonadotropin titer, a sometimes low basal metabolic rate, an elevation of blood sodium, and a reduced blood potassium, together with an increased urinary excretion of 17-ketosteroids. The alkaline phosphatase was also somewhat elevated.

THE FINAL DIAGNOSIS

When confronted with this set of facts one can hardly avoid the diagnosis of pituitary basophilism or the existence of a basophilic adenoma. In addition to the Cushing's disease, the case was complicated by a severe generalized desquamating dermatitis which began with a fungus infection of the feet ordinarily called "athlete's foot." That such a hypersensitive or hyperergic reaction should occur in an individual with pituitary basophilism need not seem so paradoxical. The fact that this skin lesion cleared up so dramatically following subtotal adrenalectomy would confirm the concept of a hypersensitivity reaction to some type of mycotic infection.

It is regrettable that following adrenalectomy the patient received erroneously an excessive dose of Doca,® which resulted in a return of his hypertension and which in turn led to the abandonment of further adrenal cortex replacement therapy. The development of the perirectal abscess only hastened the depletion of the waning stress mechanisms. The development of the severe abdominal pain complicated the final picture, and in a clinical sense obscured the more subtly approaching symptoms of total adrenal insufficiency.

Finally, as it does so characteristically in the crisis of Addison's disease, death occurred very abruptly following a comparatively minor stressful incident, i. e., the paravertebral injection of novocain.® As the clinching evidence for this contention, I can cite the blood studies obtained on the patient on the morning of his death, which because of his death were never entered on the chart. The blood sodium was at the extremely low level of 295 mEq., the blood chloride was only 99 mEq., and the blood potassium was 20 mEq. With such data in an individual who has had a bilateral adrenalectomy and no substitution therapy for the preceding three weeks, one must conclude that death resulted from acute adrenal insufficiency.

CLINICAL DIAGNOSIS

1. Pituitary basophilism, probably with adenoma.
2. Dermatophytosis of the feet, with severe generalized hypersensitivity reaction.
3. Status post bilateral adrenalectomy.
4. Perirectal abscess.
5. Abdominal pain of obscure etiology.
6. Post-operative acute adrenal insufficiency, with death occurring in Addisonian crisis.

GENERAL CLINICAL DISCUSSION

Dr. George Hamwi: About three weeks following the operation the boy developed severe abdominal pain, nausea and persistent vomiting. This continued for about two weeks. We finally decided on clinical grounds that the pain was due to either pancreatitis or something in the region of the pancreas, and a procaine block was attempted. Could not the injection of procaine have caused his death?

Dr. Rothermich: I think the final laboratory data on his electrolytes are the significant features in his death. From that we must assume that he was sliding into a severe adrenal insufficiency state. He also had a tremendous rise in eosinophil count before he died.

Dr. J. L. Morton: His apparently normal sella turcica would not prevent a diagnosis of basophilic adenoma, as we never have seen significant enlargement in this condition. The most striking features of his skeleton were the kyphosis and wedging of the vertebrae. There was also a compression fracture visible radiologically. I would like to ask if his backache could have come from his bones?

Dr. Hamwi: He did not complain of this pain until four weeks after the operation and those films were taken six weeks preoperatively.

Dr. Morton: There is one feature which I would like to stress which is considered classical for Cushing's disease—that is the flaring and widening of the rib ends and the presence of fractures. This would suggest Cushing's disease.

Dr. Hamwi: It is very interesting indeed to visualize the tremendous changes which took place in the appearance of the patient. He was referred to us first as a type of severe myxedema, but the skin condition was far more severe than seen in simple hypothyroidism. The smooth face became more pronounced and so did his buffalo hump. Clearing of the skin condition after surgery was truly amazing; the skin then appeared smooth as that of a newborn child.

PATHOLOGICAL DIAGNOSIS

1. Basophilic adenoma of the pituitary (Cushing's disease) with:
   (a) necrosis of basophilic adenoma;
   (b) girdle obesity;
   (c) testicular atrophy;
   (d) functional hyperplasia of adrenal glands;
   (e) generalized osteoporosis with compression of vertebral bodies.
2. Focal myocardial necrosis and hemorrhage.
3. Necrotizing arteriolitis involving spleen, kidneys, pancreas.
4. Status post bilateral subtotal adrenalectomy

and appendectomy (42) days with traumatic fat necrosis in both kidney areas and tail of pancreas.

5. Pulmonary blastomycosis.
6. Accessory spleens.
7. Mild cholesterolosis of the gallbladder.
8. Chronic granulomatous dermatitis.

PATHOLOGICAL DISCUSSION

Dr. E. von Haam: The body was that of an obese white male showing typical girdle obesity with interscapular fat pad. There was occipital alopecia. The breasts were prominent and contained much white glandular breast tissue. The external genitalia were decreased in size. The legs showed pitting edema. The skin was covered with fine dry scales; the fingernails were thick and rough.

The heart was enlarged and showed some mottling of the myocardium. The lower lobe of the right lung showed an area with numerous small firm gray nodules. The lymph nodes at the carina contained some caseous material. The tail of the pancreas showed posteriorly chalky grayish-black areas of fat necrosis which extended somewhat into the gland. The fat in both adrenal and renal regions appeared indurated, hemorrhagic, and contained numerous areas of fat necrosis. Only small nodules of bright yellow adrenal tissue were found, weighing together about 1.5 Gm.

The pituitary gland appeared slightly enlarged and weighed 8.1 Gm. The anterior portion contained a cystic tumor measuring 0.7 by 1.0 by 1.5 cm. The remaining portion of the pituitary gland appeared thinner than usual.

THE MICROSCOPICAL

Microscopically the heart muscle showed many focal areas of necrosis with hemorrhage. The lung lesions proved to be blastomycosis with fungi also present in some of the lymph nodes. The skin lesion was also histologically consistent with generalized blastomycosis as described by Bush.[1] Sections through the spleen, pancreas and kidney showed arteriolar sclerosis with focal areas of arteriolar necrosis and fibrinoid degeneration. The latter foci were surrounded by periarterial inflammation. The liver showed fatty changes. Sections through the remnants of adrenal tissue showed lipoid depletion. The periadrenal fat tissue showed fat necrosis with severe inflammation and foreign body reaction.

The microscopic examination of the cystic pituitary tumor showed a basophilic adenoma with central necrosis and cystic degeneration. Many smaller basophilic adenomas were present in the remaining portion of the anterior lobe.

We may conclude, therefore, that the patient suffered from Cushing's disease with a large basophilic adenoma which had undergone cystic degeneration and must have severely interfered with the normal function of the pituitary gland. In addition to this, the patient also suffered from systemic blastomycosis of lungs, lymph glands, and probably the skin, which explains the severe dermatitis the patient had during the last years of his life.

Following his operation the patient then developed fat necrosis in his retroperitoneal fat tissue, which explains the severe intractable pain he suffered. The fat necrosis may have been due directly to surgical trauma or perhaps was a consequence of his vascular lesions. The process did not extend into the pancreas to any degree and did not involve the mesenteric fat tissue. This may explain the negative tests for amylase in spite of the clinical symptoms of pancreatitis.

The acidophilic or fibrinoid degeneration in many of his small arterioles with medionecrosis and inflammatory changes identical to periarteritis nodosa constitutes a very interesting finding. We can only suggest that these changes, as well as the focal necrosis of his heart muscle, may have been due either to his rapidly changing electrolyte balance or to the absorption of some toxic substances from his wound bed.

It is our opinion that the foci of myocardial necrosis and myocardial hemorrhage probably represent the most likely histological basis for his death.

GENERAL DISCUSSION

Dr. J. M. B. Bloodworth: Special stains of the adrenal tissue removed by surgery showed a marked increase of total cholesterin in the adrenal cortex. Staining with fuchsin gave a negative reaction. Most of the remaining adrenal tissue proved to be necrotic. Only small areas appeared to have functioned before his death.

Dr. Rothermich: I think that we cannot overlook the low sodium content of the blood at the time of his death. It suggests that the man died as people with Addison's disease die in adrenal crisis, i.e., very abruptly and without apparent adequate cause. I think that Dr. von Haam's suggestion interpreting the skin lesion as a hypersensitivity reaction to a fungus disease is quite interesting. Hyperfunction of the adrenal cortex would explain such an exaggerated reaction.

Dr. Hamwi: I think that Dr. Rothermich's interpretation of the final demise is probably true. The only puzzle that remains is that the patient did not die sooner from adrenal deficiency. The course of final events was the same as reported by Albright[2] and others from the Mayo Clinic. I differ with Dr. Rothermich and Dr. von Haam in the explanation of the skin lesions. I think that the depletion of the adrenal cortical hormone does not prevent the occurrence of sensitizing reactions. ACTH and large doses of

cortisone would not act as anti-allergic substances as they admittedly do.

DR. ROTHERMICH: There can be no question that the extensive fat necrosis would account entirely for the complaints of abdominal pain. The fat necrosis must have resulted from escape of lipase into the abdominal cavity. We still have no adequate explanation for its presence in this case. The description by Dr. von Haam of the diffuse and spotty myocardial necrosis, together with the fibrinoid or acidophilic degeneration in many arterioles is very intriguing. These findings were also present in the vessels of the spleen, the pancreas and the kidneys as well as the heart muscle. Dr. von Haam compares these changes with those seen in periarteritis nodosa. Selye[3] has described identical lesions in animals receiving toxic doses of Doca.® Our patient, after adrenalectomy, had also received what must be considered a toxic dose of Doca® and died later in adrenal insufficiency. It may well be conjectured that his vascular changes constitute a confirmation of Selye's animal experiments.

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Disorders of the Small Intestine

Kuntz regards allergic reactions as functional disturbances which involve primarily tonic changes in the musculature of viscera. These reactions are to be attributed to deviations from the normal autonomic balance, produced by "heightened parasympathetic or cholinergic reactivity."

Allergic reactions in the gastrointestinal tract responsible for symptoms are uncommon and are usually difficult to detect. We have seen a transit time of one-half hour or less and hypertonicity, particularly of the lower half of the small intestine, in patients whose symptoms were relieved by the elimination of some food, for example milk or eggs, from the diet. However, allergic phenomena manifest many vagaries. A rapid transit time and hypertonicity of the intestine are merely evidences of parasympathetic overactivity which in any given instance might be the background for allergic responses, and therefore do not justify a diagnosis. The examination of the small intestine is done with opaque material from which possible allergens are excluded. In the presence of an allergen, transit time may be slowed and abnormal segmentation of the barium shadows may appear.—Ross Golden, M. D., New York, N. Y.; *Minnesota Medicine*, 35:930, October, 1952.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Idiopathic—This term designates a disease of spontaneous or unknown origin, and is derived from the Greek words "idios" meaning peculiar to one's self, distinct, or one's own; plus the Greek "pathos" or disease. This term probably comes from the idea that diseases of unknown origin come from within one's self and are not acquired from without. Thus they are "idiopathic" by being diseases peculiar or distinct to one's self.

Trocar—This term which is derived from the French words "trois" or three and "carre," an angle, is used to designate a sharp triangular pointed instrument which fits into a hollow cannula and is used to withdraw accumulations of fluids from various body cavities. This type of instrument was devised by Paul Barbette, a 17th Century French surgeon. However, forerunners of this instrument, which consisted of a simpler type of hollow tube were used by the Greco-Roman physicians for the same purposes.

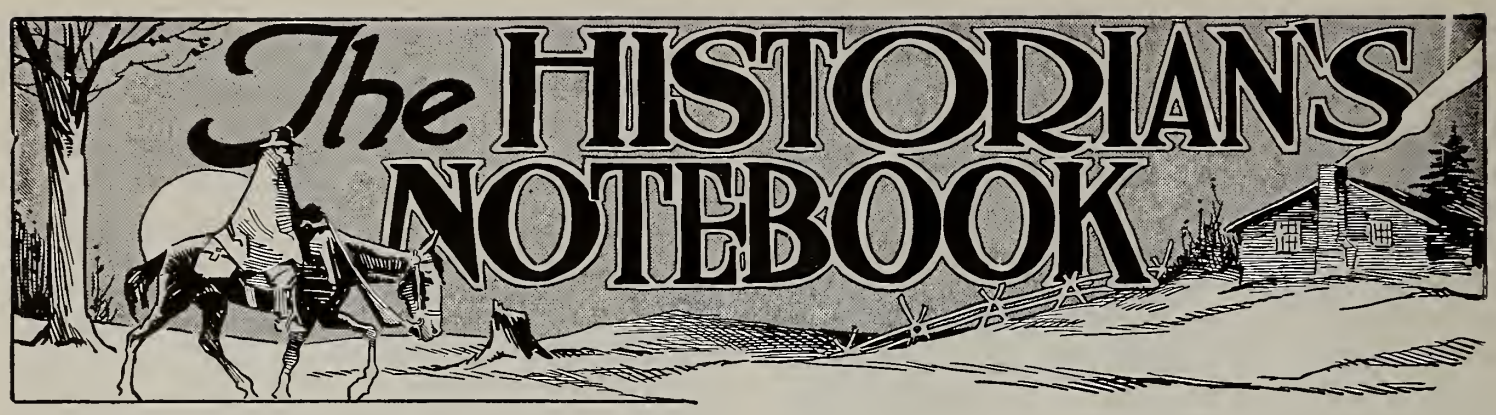
Meconium—This is a descriptive term which is applied to the first fecal discharges of newborn infants. The name was given because these stools bear a resemblance to the thick crude juice of the opium poppy. The term meconium is derived from the Greek word "mekon," a poppy.

Itch—This word has descended to us from the Anglo-Saxon word "giccen," which later became "icchen" and thence evolved into itch. The term has always designated an irritation or sensation of the skin causing a desire to scratch. The word "itch" has also become synonymous with scabies. While the "itch-mite" of scabies was discovered in the 12th Century by Avenzoar, it was first called the "itch-mite" in the 18th Century by Wichmann.

Torso—This term which now designates the body without head or limbs is an Italian word meanning "the stump of a cabbage." It is derived from the Latin word "thyrsus" and the Greek word "thursos" both meaning a stem. Hence the torso is literally the stump or stem of the body.

Hives—The name of this allergic skin condition which is characterized by raised wheals and welts originated in Scotland and the North of England, and was applied because of the fancied resemblance of the raised wheals to a beehive. The word "hives" comes from the Anglo-Saxon word "hige" meaning a household. Later this term came to be applied to a box, basket or house for bees, hence a beehive. It is also suggested that the term "hives" comes from "heave" and the Anglo-Saxon word "hebben," meaning to lift or raise.

—HARRY WAIN, M. D., Mansfield, Ohio.



The Past Is Prelude

The Last Fifty Years Bespeaks Still Greater Things In the Future of American Medicine

HOWARD T. KARSNER, M.D., LL.D.

INTRODUCTION

THE invitation to speak on this occasion is one of the great compliments of my career, and I cannot fully express my gratitude. I am happy to be with you and to share in this celebration which marks the first half-century in the life of the Academy of Medicine of Cleveland. My assignment is to review the progress of medicine in this period. As it happens, I graduated in medicine just a year after the Academy was founded and, thus, have a certain first-hand acquaintance with what has transpired in these fifty years. I had the good fortune to spend nearly half my life in Cleveland and know something of what the doctors of this city have contributed to the advancement of the profession. The time allotted naturally will permit a review of only some of the highlights of the notable achievements in which medicine takes justifiable pride.

My natural inclination would be to discuss medical research, but you are more likely to be interested in concrete applications. I cannot refrain, however, from pointing out that research is the basis of our advancements, not only research which is directly applied but more particularly those basic or fundamental investigations pursued only with the purpose of enlarging the field of human knowledge.

In development of my theme, I cannot overlook the fact that achievements of preceding years and ages, slow at times and gaining speed in the nineteenth century, provided the background for the thrilling acceleration of the first half of the twentieth century. "The present century grasped this rich heritage with both hands and proved itself not unworthy of the gifts it had received."

In spite of present emphasis on organization in research, the advances have been initiated by individuals, "men of questing minds and devoted spirits." Many such men have lived and worked in Cleveland, but time permits the mention of only a few in this brief address.

In these fifty years, research, medical education and organized medicine have played their part in learning about the causes, course, detection, prevention and treatment of disease. The contributions to health, comfort and prolongation of life testify to the productive efforts of medicine and its allied sciences, including dentistry, nursing, dietetics and the laboratories. The advances in these fields are significant but cannot all be included in this address. However, special mention should be made of the stimulus to nursing education by the Frances Payne Bolton School of Nursing.

CAUSES

The expression "the cause of disease" is oversimplification because there are many factors concerned which are interrelated. When this half-century began, the association of bacteria with communicable diseases had been well established, and certain other forms of parasites, such

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The opinions and views set forth are those of the writer and are not to be construed as reflecting the policies of the Department of the Navy.

as that of malaria, were well known. We knew also of higher parasites, such as worms of different kinds. Smaller organisms, the rickettsiae, were identified in our time, and potent vaccines against such diseases as Rocky Mountain spotted fever and epidemic typhus fever have been prepared. The latter was of especial importance to American troops in World War II, particularly in the African Campaign.

When the Academy was formed, viruses were little more than a name for the agents of smallpox, rabies and yellow fever. Much has been learned about their connection with other diseases such as poliomyelitis (a subject forwarded here by the work of Toomey), influenza and many others. They can be cultivated only in living cells, are so minute they pass through the pores of porcelain filters, but are known more for what they do than what they are.

The various infective agents are essential to the onset of specific diseases, but in these five decades much has been learned about the way they and the bodies of their victims act together to produce disease. These matters of virulence, resistance, age, sex, social conditions, heredity, constitution and the like all interact in the development of disease. No one is the cause; all act together in causation.

This is by no means the whole story, because we suffer from conditions not directly associated with infectious diseases. There are disturbances of nutrition as well as internal derangements of metabolism. For example, we have discovered the relation of inadequate diet to certain forms of dropsy and of deficiencies of certain foods to cirrhosis of the liver, pellagra and other diseases. And in this half-century the significance of vitamins has been established. Furthermore, disorders can be attributed to deficiencies of proteins as well as faults in their behavior in the body, and also to similar changes in certain of the building blocks of proteins, the amino acids. The place of minerals in bodily functions has also been studied.

Cleveland can take lasting pride in the discoveries made here on the nature of high blood pressure. Initiated by the epochal work of Goldblatt on experimental hypertension, further advances have been made by Page, Corcoran, Scott and others. Through the basic knowledge so contributed, prevention and cure can ultimately be anticipated. We think also of the contributions on function and diseases of the kidneys made by Wearn, Hayman and others. The so-called degenerative diseases are being extensively investigated.

ENDOCRINOLOGY

Outstanding is the remarkable development of the study of the glands of internal secretion. These glands are all small and some are even tiny. In proportion to their size, it is amazing what they can do. Nearly all bodily functions are under their control, so that abnormal activity of some of them can account for disease. And they are so closely interconnected that disease of one is reflected in other members of the group.

Cleveland was in the forefront of investigations of disorders of the thyroid gland, notable for the work of Marine and Lenhart, and the results had immediate practical application. Among the early studies of the adrenal glands were those of G. N. Stewart, Rogoff and their associates who did and stimulated work of far-reaching importance.

In the background of investigations conducted here, J. J. R. Macleod was a co-discoverer of insulin, and the practical application was advanced by many in this city. Our endocrinologists and surgeons have added greatly to the knowledge of the action and cure of tumors of several of these glands.

NUTRITION

Cleveland medicine has played a large part in studies of nutrition. Gerstenberger's work on rickets, Spies' studies of pellagra, the research of Beams and associates on cirrhosis of the liver, Goldblatt's studies of vitamin deficiencies and that of members of our surgical staff on postoperative nutrition and bed rest have established leadership in these fields.

And in today's idiom, what a beating bed rest has taken in the last two decades! Time was when a patient with coronary occlusion was put at complete bed rest for three months, but now he is given by some the "armchair treatment," a modality based on logical pathophysiological reasoning. As for childbirth, we are almost back to the methods of the savages! Surgical patients are practically booted out of bed so that they are ready to stand and walk days before the stitches are removed. This is no fad but a procedure based on known principles, most of them newly discovered.

COURSE

If the doctor is to do his job thoroughly, he should know not only how a disease originates but how it may run its course to recovery, progress to a chronic stage, or lead to death. He learns its natural history and, by this, is guided in its management. For example, we may turn to the subject of cancer. You will ask if the cause has been discovered and the answer is "no." This is partly because we have learned from experiment and from observations on man that cancer is not a single disease but many.

Much has been learned in our half-century of environmental and other factors which lead to some of these forms, and preventive measures have been instituted. Furthermore, these discoveries may point the way to knowledge of the basic disturbances which result in uncontrolled growth of cells.

Single calendar years of study produce only

small advances. Yet we now know much of the natural history of some forms and the methods of treatment. This knowledge is used in informing patients and their relatives as to the outlook for the individual case. Only those whose dear ones have been afflicted understand how comforting a wise prediction can be. Not only is this true of cancer but it applies also to diseases of the heart and numerous other organs.

DIAGNOSIS

If the doctor is to treat his patients intelligently, he must know what is wrong with them; he must make an accurate diagnosis. In our half-century he has improved his analysis of his patient's history, has increased his skill in physical examinations and has added revealing adjuncts. He has realized that he must know psychic factors, sociological background and environmental conditions. His patient is more than a case; he is a human being.

The doctor has increasingly turned to the laboratory for technical aid and in this field there are many new developments. The doctors who established the Academy barely knew of the clinical method for measuring blood pressure. They had yet to learn of the blood tests for syphilis, and we can point with pride to what Clevelanders such as Ecker and Kline did in the refinement of these tests. Bacteriological methods have been vastly improved. Chemical examinations of blood, body fluids and tissues have been introduced. Identification of tumors or other structures removed by the surgeons is on a firm basis.

But turning to the laboratory should not mean leaning on it. The laboratory is a tool for diagnosis but only rarely does it make a diagnosis. The doctor uses his hands to get material for the laboratory but he must use his brain to know what to select and how to interpret the results.

Numerous other methods of diagnosis have added enormous advances. Irregularities of the heartbeat were known but their mechanism was obscure. In our half-century the polygraph shed much light, but this was soon superseded by the electrocardiograph. Our doctors became expert in the use of this instrument and added to the interpretation of its revelations. There have been added the vectorcardiograph, the ballistocardiograph, electrokymography and angiocardiography. The electro-encephalograph has also proved to be a most useful tool. Medicine has entered new fields, and the doctor must be a physicist of sorts and an electronics expert as well.

And in the past few years the study of circulation has turned to the use of the catheter introduced for examination of disorders of the heart, both for determination of how this organ functions in diseases and for identification of anomalies of its development. Furthermore, it is used in investigation of functions of the lungs, kidneys and liver.

I was a high school boy when Roentgen announced his discovery, and when the Academy was founded the doctors were only familiar with photographs of the bones of the hands. Indeed, one of our older members scathingly referred to roentgenologists as mere photographers. It would be a platitude to review the remarkable developments in this field. From identification of fractures and guidance in their treatment and determination of the situation of foreign bodies, it has progressed to include diagnosis of diseases of the lungs, heart and great vessels, study of stomach and intestine and it searches inside the skull. Radiology was early instituted in Cleveland, and its cohorts have become eminent in the field.

PREVENTION

Although vaccination against smallpox, rabies and a few other maladies was known in the nineteenth century, most preventive measures have originated since the Academy was founded. With impetus provided by Howard and Perkins, Cleveland was one of the first cities to assure its citizens of water, so treated that it would not carry disease, especially typhoid fever. It was early in the field of food inspection. Its Department of Public Health has developed into leadership. Its clinicians and scientists have attained eminence in the study of immunization. The purest toxoids now known were developed here by Pillemer and his group. Preventive medicine is not confined to measures such as these, but also has investigated means by which an acute disease can be prevented from the development of crippling sequels or becoming chronic.

TREATMENT

Treatment is but one facet of the management of the patient. In that management are psychological, psychiatric, sociological and human factors which have been appreciated only in more recent times. Cleveland surgeons were among the first to insist on as accurate a diagnosis as possible before cutting into a patient and on handling tissues gently after they did. In these years, asepsis has developed as an exact art.

Techniques have been improved so that operations are now performed which were not more than hopeful dreams fifty years ago. Witness the frequent operations in the cranial cavity by Cutler, Gardner and others, those in the chest and on the heart by Beck, and the marvelous surgical procedures of Jones. Much of the success has been due to advances in the art and science of anesthesia; a new science of anesthesiology has been born. Patients can now be anesthetized so that the surgeon can work with-

out anxiety and the patient not only be free of pain but recover with little or no after effect.

Although diphtherial and tetanal antitoxins were well known when the Academy started, they have been vastly improved and many other immune serums have been successfully introduced. Serums have been prepared against certain vitamins and antagonists to some of the vitamins are now being tested. And we cannot overlook treatment by x-rays, by radium and by the various radioactive isotopes.

SHOCK

The fruitful imagination of Crile made Cleveland a pioneer center for the study of postoperative and other forms of shock. Among the methods of preventing and treating shock is the use of blood transfusions. The testing of blood so that transfusions became safe was not introduced in a practical way until 1916, which was the basis for this procedure in World War I in the United States Army and Navy and among the British and other allied forces. The Lakeside Hospital Unit in France played a large part in this progress. Since then discoveries have followed one on another, with applications in internal medicine, obstetrics and forensic fields.

At the present time we are confronted with mass casualties, and efforts are underway to devise substitutes for blood plasma which might well be in short supply. And studies are directed toward the prevention of infectious jaundice or hepatitis, which hampered military operations in World War II and has been of serious moment among civilians.

CHEMOTHERAPY AND ANTIBIOTICS

Medical treatment has leaped forward. Many will remember the success of that 606th preparation devised by Ehrlich. Chemotherapy was on its way with its efforts to destroy the agents which incite disease without harm to the patient. To be sure, malaria had been treated by chemotherapy, but that was empirical and only became scientific in later years. Then came the discovery of prontosil in the Farben Industrie, ill-famed for a time, and from this came the production of the many sulfa drugs.

Next came the antibiotics. A casual observation on a Petri plate was recorded and remained buried in scientific literature until a group of men in Britain and the United States took hold and made penicillin a household word. The number of antibiotics is ever on the increase, and the diseases which they control form an expanding list. The applications of chemotherapy and of antibiotics extend into all the specialties of medicine.

There is also substitution therapy. In our day we have seen pernicious anemia conquered. We see endocrine therapy advancing, and we do not forget, as previously noted, that a former Clevelander led the way in the production of insulin. Products of the pituitary gland and the adrenals have their place in specific treatment, but there is still much to be learned. Disorders of the thyroid are subject to successful attack by use of its secretions, of newly discovered drugs and by irradiation, both external and internal.

PHYSICAL THERAPY

Physical therapy in a limited way was known when the Academy started, but has been strikingly advanced by improvement of older methods and the introduction of many new modalities, not the least of which is diathermy. The same is true of psychotherapy, based on studies of personality and its vagaries. Notable in this field has been the introduction of the class method of re-education and adjustment. And we raise the flag to radiotherapy, the progress of which savors of the miraculous.

CHANGED TYPE OF PRACTICE

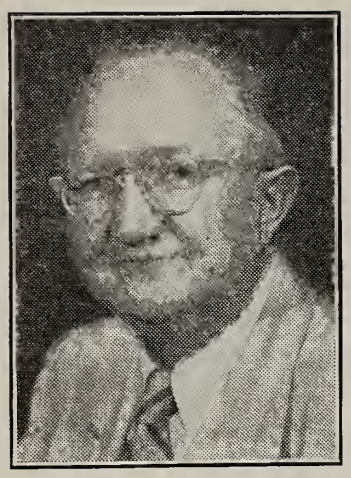
Medical practice has changed in many respects, partly perhaps because of fluctuations in incidence and severity of some diseases, and partly because of preventive measures and modern treatment. For example, teachers are put to it to demonstrate to their students diseases formerly common, such as typhoid fever, lobar pneumonia, locomotor ataxia and paresis. Other diseases can now be provided for their classes like infectious jaundice and atypical pneumonia.

The increased span of life has altered certain aspects of medical practice, our modern culture and even politics. Whereas in the days of Pericles the average length of life was about 18 years, it slowly rose in 2000 years to 33 years and in our half-century to almost 70 years. Geriatrics and gerontology have added much to our knowledge of the afflictions of old people. By methods recently developed, the aged survive illness, injury and surgical operations, many of which would have been fatal a few years ago. It may be that the new generation of oldsters is tougher than their predecessors, but there is no doubt that medicine is able to give them improved care.

Doctors are among those who are charged with the obligation to see to it that "a full life is measured not by length alone but also by depth and breadth." I wish that time permitted elaboration of the wonders of the newly developed field of rehabilitation. It challenges our medical people to re-educate, readjust, and improve the lives of handicapped people of all ages.

MILITARY MEDICINE

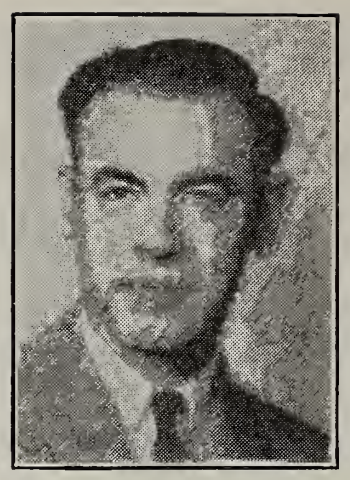
Military medicine has been a preoccupation with many Clevelanders, as distinguished officers in the Armed Forces and as members of affiliated hospitals, notably that unit which was the



L. R. DRAGSTEDT, M.D.
Chicago



ROBT. D. DRIPPS, M. D.
Philadelphia



R. H. CHAMBERLAIN, M.D.
Philadelphia



RALPH A. REIS, M. D.
Chicago

agology, Temple University School of Medicine, Philadelphia.

He is a graduate of the University of Pennsylvania School of Medicine, 1926, and holds the following distinctions: Diplomate, American Board of Otolaryngology; member, American Association for Thoracic Surgery; American Academy of Ophthalmology and Oto-Laryngology; American Laryngological Association; American Laryngology, Rhinology and Otology Society; American College of Surgeons; American Broncho-Esophagological Association; American College of Chest Physicians and American Trudeau Society.

Dr. Jackson will speak on Wednesday morning on the subject, "Bronchoscopy in Relation to Thoracic Surgery," and to the E. N. T. Section in the afternoon on the topic, "Current Trends in Treatment of Cancer of the Larynx."

Joseph B. Kirsner, M. D., is professor of Medicine, University of Chicago School of Medicine. He received his M. D. degree from Tufts College Medical School, Boston, in 1933, and is a diplomate of the American Board of Internal Medicine, a member of the Central Society for Clinical Research and of the American Society for Clinical Investigation.

"Management of Peptic Ulcer" will be the topic of his talk at a Thursday General Session from 9:30 to 10:00 a. m.

John K. Lattimer, M. D., New York City, is a graduate of Columbia University College of Physicians and Surgeons, 1938, and is a Fellow of the American College of Surgeons.

"Treatment of Renal Tuberculosis with Isonicotinic Acid Hydrazid, Streptomycin and PAS" is his subject to be discussed at a General Session on Tuesday from 10:00 to 10:30 a. m. Before the Section on Urology, he will speak on the subject, "Current Therapy for Genito-Urinary Tuberculosis," from 2:10 to 2:50 p. m., Tuesday.

Ralph A. Reis, M. D., Chicago, is professor of obstetrics and gynecology at Northwestern University Medical School. He is a diplomate of the American Board of Obstetrics and Gynecology; member of the American Gynecological Society, Central Association of Obstetricians and Gynecologists, American College of Surgeons. School of graduation is Northwestern University Medical School.

"A Reevaluation of Endocrine Therapy in Obstetrics and Gynecology" is his subject, scheduled for 11:15-11:45 a. m., Tuesday during a General Session. Before the Section on Obstetrics and Gynecology, on Tuesday afternoon he will open a round-table discussion on "Sex Hormone Therapy in Gynecology."

Louis M. Rousselot, M. D., professor of clinical surgery, New York University College of Medicine, is a diplomate of the American Board of Surgery and member of the Society of University Surgeons. He is a graduate of Columbia University College of Physicians and Surgeons, 1927.

"Surgical Therapy in Portal Hypertension with Particular Reference to Selection of Cases" is his scheduled topic for discussion before a General Session on Thursday from 12 noon to 12:45.

Andrew S. Tomb, M. D., Victoria, Texas, is nationally known as a general practitioner and especially for his work in the field of alcoholism. He has served as president of the Texas Academy of General Practice; he formerly was chairman of the Committee on Alcoholism for the Texas State Medical Association; he has served on the Education Commission and Committee on Scientific Assembly of the American Academy of General Practice, and was moderator of a panel discussion on "Problem Drinking" at the Scientific Assembly of the American Academy of General Practice in Atlantic City last year. Also he has written extensively on the subject of management of alcoholism.

"Medical Management of the Problem Drinker" will be discussed by Dr. Tomb from 11:45 a. m. to 12:15 p. m. on Wednesday during a General Session. Before the Section on General Practice, on Wednesday from 2:00 to 2:30 p. m., he will discuss "Needle Therapy."

George M. Wheatley, M. D., is third vice-president, Metropolitan Life Insurance Company, New York City. A graduate of Harvard Medical School, 1935, he is a diplomate of the American

Board of Pediatrics, and a member of the American Academy of Pediatrics and the American Public Health Association.

"The Prophylaxis of Accidental Trauma" will be his topic at a General Session on Wednesday from 10:00 to 10:30 a. m. On Wednesday from 2:00 to 2:30 p. m., he will speak before the Section on Pediatrics on the subject, "The Child Accident Problem."

Recent Experience Indicates That Diathermy Equipment May Be Converted at Saving

Ohio physicians who have on hand diathermy apparatus manufactured prior to mid-1947 may be interested in an article which appeared in the January 3 issue of *The Journal of the A. M. A.* The article relates experiences under which some of these pieces of apparatus have been converted economically to comply with the Federal Communications Commission ruling.

The A. M. A. Council on Physical Medicine and Rehabilitation had previously obtained estimates which indicated that conversion would be expensive and impractical. It has since learned that the Defense Department has converted many of its units at considerable savings and that some hospitals have done the same.

The Federal Communications Commission Ruling was issued in 1947 and set a five year limit on the use of equipment which did not meet specifications as to frequencies. The period of grace expired June 30, 1952.

It may be to the advantage of physicians who have such equipment on hand to obtain estimates as to cost of conversion.

Heart Association Publishes Booklet on Diet

The American Heart Association and its affiliates have published a booklet, "Food for Your Heart," which incorporates nine diets, sample menus, and information on nutrition and heart disease. The booklet is for lay readership but is being distributed only through physicians and professional organizations. Physicians may write for one or more copies to the Ohio State Heart Association, 55 E. State St., Columbus 15, or any of its affiliates.

Opinion of Attorney General

The syllabus of Opinion No. 1869, recently rendered by Attorney General C. William O'Neill is as follows: "Coroners—Traveling expenses—County coroners may be reimbursed for their necessary traveling expenses incurred by them while using their personally owned automobiles on their official business." (Opinion No. 2187 of 1950, overruled.)

American Academy of General Practice Announces Program for St. Louis Meet

The American Academy of General Practice has announced the features of its Fifth Annual Scientific Assembly to be held in the Kiel Auditorium, St. Louis, Monday, March 23 through Thursday, March 26. The program appears on page 147 of this issue.

Leonard Reed, president of the Foundation for Economic Education, Irvington-on-Hudson, New York, will be the banquet speaker on March 25.

Several Ohio doctors are taking prominent parts in the Assembly, among them, are:

Dr. Robert A. Lyon, associate professor of pediatrics, University of Cincinnati College of Medicine, who will speak on "Heart Disease in the First Year of Life."

Dr. W. A. Altemeier, assistant professor of surgery, University of Cincinnati, who will speak on "Antibiotics in Surgery."

Dr. Joseph Lindner, Cincinnati, is chairman of the Exhibits Committee, which has arranged scientific exhibits to correlate with the program.

Hotel reservations must be made prior to February 23 with the Hotels Convention Reservation Bureau, A. A. G. P., Room 406, 911 Locust St., St. Louis 1, Mo. Information relative to the 1953 Post-Assembly Meeting in Mexico City may be obtained from Lee Kirkland Travel, 1231 Baltimore Ave., Kansas City 5, Mo.

Dr. Earl D. McCallister, 1113 Bryden Road, Columbus, secretary-treasurer of the Ohio Academy of General Practice, is secretary of the State Officers' Conference of the American Academy of General Practice, and will succeed to the presidency at the Cleveland meeting next year.

All members of the medical profession are invited to attend.

Dr. Forman Heads National Garden Institute

Dr. Jonathan Forman, Editor of *The Journal*, was elected president of the National Garden Institute, at its recent annual meeting in the LaSalle Hotel, Chicago, in connection with the Annual Garden Supply Mart. He has been a member of the organization's board of trustees for the past two years. The Institute is an organization which attempts to interest amateurs and educate them in the pleasures and healthful benefits to be gained from gardening.

Problems besetting medical schools and licensing boards will be discussed at the 49th annual Congress on Medical Education and Licensure, to be held at the Palmer House, Chicago, February 8-10. The Congress will be sponsored by the Council on Medical Education and Hospitals of the American Medical Association and the Federation of State Medical Boards of the United States.



Mark These Dates

On Your 1953 Calendar

And Make

Hotel Reservations Now

for the

1953 Annual Meeting

Ohio State Medical Association

Cincinnati, Ohio . . . April 21, 22, 23

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BED
NETHERLAND PLAZA HOTEL	$5.50-12.00	$10.00-12.50	$10.50-15.50
ALMS HOTEL			$8.70-9.70
BROADWAY HOTEL	$3.50	$5.50-6.50	
CINCINNATIAN (Formerly Palace)	$2.50-4.00	$4.00-6.00	$5.00-7.00
FOUNTAIN SQUARE HOTEL	$4.50-6.50	$6.50-9.50	$8.50-9.50
METROPOLE HOTEL	$4.00-8.00	$6.50-8.50	$6.50-10.50
SHERATON-GIBSON HOTEL	$5.00-12.00	$7.50-12.00	$9.00-15.00
SINTON HOTEL	$5.00-12.00	$6.50-11.00	$9.00-11.00
TERRACE PLAZA HOTEL	$9.00-15.00		$12.00-18.00
VERNON MANOR		$4.00-6.00	$5.00-9.00

(Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager.....Hotel, Cincinnati, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 21, 22, 23, 1953, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Suite

Arriving April..... at.....A. M..... P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

A. M. A. House of Delegates . . .

Boiled-Down Facts on Business Transacted At Recent Denver Session; Ohio Delegates Take Prominent Part by Service on Reference Committees

BELIEVING that some Ohio physicians have not had an opportunity to study carefully the minutes of the sessions of the House of Delegates of the American Medical Association held in Denver, December 2-4, 1952, which were published in *The Journal of the A. M. A.*, a boil-down report on the transactions has been prepared by the staff of *The Ohio State Medical Journal.*

The Ohio State Medical Association was represented in the House of Delegates by the following: Dr. Carl A. Lincke, Carrollton; Dr. George A. Woodhouse, Pleasant Hill; Dr. William M. Skipp, Youngstown; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. A. A. Brindley, Toledo; and Dr. Herbert B. Wright, Cleveland. Dr. Paul A. Davis, Akron, represented the Section on General Practice.

The following Ohio delegates were named on reference committees of the House: Dr. Wright, Committee on Reports of Board of Trustees and Secretary; Dr. Lincke, Committee on Executive Session; Dr. Woodhouse, Committee on Medical Military Affairs; Dr. Sherburne, Chairman, Committee on Sections and Section Work.

Dr. Edward J. McCormick, Toledo, was present in his official capacity as President-Elect of the A. M. A.

MILITARY SITUATION; VETERANS

Two of the most important and controversial questions considered by the A. M. A. House of Delegates were covered in an article published in the January issue of *The Ohio State Medical Journal*, pages 63-65, namely: the Doctors' Draft Law and the military situation, and medical and hospital care of veterans with non-service-connected disabilities.

Following are brief comments on other business matters handled by the House of Delegates:

PRESIDENT'S ADDRESS

In his address to the House, Dr. Louis H. Bauer, President, discussed the need for a more equitable distribution of physicians; revision of specialty board requirements to the end that more physicians be required to start in general practice before qualifying for a specialty; re-emphasis on and enforcement of the Principles of Medical Ethics; expansion of emergency call services; and legislative matters which confront the medical profession.

NURSING SHORTAGE STUDY

The House directed the Board of Trustees, through its Commission for the Improvement of the Care of the Patient, to institute a comprehensive study of the nursing situation, with particular study being devoted to such subjects as: (a) The number of nurses now available for bedside nursing; (b) The number of nurses needed and the number now in training; (c) The Accreditation Program for Schools of Nursing and the effect which it is having on schools of nursing; (d) Exploration of the possibility of having in addition to the present period of nurse training of three years, the development of a shorter period of training; (e) The need and desirability for training and accrediting practical or vocational nurses.

CLINICAL PSYCHOLOGISTS

The matter of the licensure or certification of clinical psychologists was dealt with in a supplementary report of the Board of Trustees which was adopted by the House of Delegates.

The report recognized that "clinical psychologists may have need for standardization of their qualifications within their own field of endeavor for the purpose of preventing encroachment by those having insufficient education and training." However, it further stated:

"Since the Committee is convinced that clinical psychologists cannot in any way be qualified by their training and experience to function independently as psychotherapists, "it seems necessary that the A. M. A. adhere to a policy which defines the practice of psychotherapy as an integral part of the practice of medicine and therefore present a medical point of view in relation to any attempt at legal recognition of clinical psychologists."

The Board pointed out that its recommendation does not interfere in any way with the duties of ministers, counselors, lawyers, teachers and others who utilize psychological understanding and principles in the carrying out of their particular work.

RELATIONS WITH LAY WORKERS

The House recommended that the Board of Trustees give consideration to establishment of a permanent bureau in the headquarters of the A. M. A. to deal with problems arising concerning the relationship between medical practitioners and lay workers in auxiliary fields of medicine.

DEFINITION OF DENTAL SERVICES

A resolution presented by the Section on Laryngology, Otology and Rhinology, requesting that the Board expedite establishment of a defi-

nition of medical and dental services, was approved.

RECOMMEND WITHDRAWAL FROM ILO

The House approved a resolution which recommended that the United States withdraw as a member of the International Labor Organization. The House further reaffirmed its endorsement of the proposed amendment to the Constitution of the United States relating to ratification of treaties and covenants which has been proposed by U. S. Senator Bricker of Ohio.

GOVERNMENT IN MEDICINE

An attempt to survey the extent to which local, state and Federal governments are responsible for the provision of personal medical services to various groups of people in our population was advocated in a resolution adopted by the House.

WANT ADVISORY BOARDS CONTINUED

The House endorsed the continuation and expansion of civilian medical advisory boards and committees to insure that governmental medical plans and programs serve the best interests of the Federal government and civilian medical care. To that end, it resolved to urge the President-Elect of the United States and appropriate department heads to take whatever action is necessary to effect such medical advisory boards and committees.

U. S. DEPARTMENT OF HEALTH

The House adopted a resolution recommending creation of a Federal Department of Health with cabinet status.

SPECIALISTS—GP's

The House directed the Speaker to appoint a committee to study a proposition that specialty boards require as a prerequisite to certification that the applicant must have served one or more years in private general practice. The purpose of such a prerequisite on the part of boards would be to tend to cause a greater flow of young doctors into smaller communities and rural areas.

RESIDENCIES IN GENERAL PRACTICE

It referred to the Council on Medical Education and Hospitals a resolution asking the council to encourage hospitals to provide adequate residency space for proper training of general practitioners, such programs to be approved on a one, two or three year basis.

CERTIFYING BOARDS

Approval was given a recommendation of the Board of Trustees that the A. M. A. recognizes and approves only one certifying board in each of the specialties of medicine, namely those boards established by the Advisory Board of Medical Specialties and the Council on Medical Education and Hospitals of the A. M. A.

PRACTICE RULED UNETHICAL

The practice of some hospitals requiring all physicians using the hospital to pay to it a certain percentage of fees received from hospital patients is unethical, the House ruled.

TENURE OF OFFICE

A procedure was established whereby tenure of service on the various Standing Councils and committees of the A. M. A. is limited to two terms of five years each, except in those instances in which an individual is selected to fill an unexpired term of less than three years duration. Expiration dates have been established also for present members of these groups.

ACTION ON PATENTS

The House concurred with the Board of Trustees in its decision that the A. M. A. should not undertake a patent management program in any form, but expressed its hope that physicians would undertake such a program independent of the Association. The matter came from a previous request that the Board study the policy of engaging in the patent management business or acquiring and licensing patents for royalties, the proceeds to be used to aid approved medical schools.

STANDARDIZED FORMS

The House recommended that the Council on Medical Service continue its study of the simplification and standardization of health and accident reporting forms.

PROFESSIONAL LIABILITY INSURANCE

The House recommended that the Board of Trustees have the appropriate council study the professional liability insurance situation.

REED-KEOGH BILLS

The House approved in principle the contents and intentions of the Reed-Keogh Bills and recommended their support if and when such bills are reintroduced before Congress. The bills have to do with deductions for income tax purposes of funds put into retirement pension plans for self-employed individuals, including physicians.

RELATIONS WITH OSTEOPATHS

The House directed the special committee previously appointed for that purpose to report at the next session on the application of the Principles of Medical Ethics to physicians' relationships with osteopaths. The Judicial Council reported that "in the absence of a directive from the House of Delegates, and in the absence of any alternative statement from the osteopaths themselves that they no longer adhere to their original cult theories, the Judicial Council reasserts its opinion that all voluntary associations with osteopaths are unethical."

County Society Officers' Conference . . .

Local Presidents, Secretaries and Certain Committee Heads To Meet At Netherland Plaza, Cincinnati, on Afternoon Before Annual Meeting

A CONFERENCE of Presidents, Secretaries and certain committee chairmen of all County Medical Societies will be held at the Netherland Plaza Hotel, Cincinnati, on Monday afternoon, April 20. Members of the House of Delegates also are being invited.

This important event will take place on the afternoon immediately preceding the 1953 Annual Meeting of the Ohio State Medical Association, opening Tuesday morning, April 21, and closing Thursday, April 23, in Cincinnati.

Invitations are in the mail for this conference which will provide an opportunity for County Medical Society leaders to kill two birds—take in the conference and remain over for the Annual Meeting.

Those planning to attend the Monday, April 20 conference, should take this into consideration when writing to Cincinnati for hotel reservations. They will want to start their hotel reservations Monday, April 20. See page 138 of this issue for information on Cincinnati hotels and how to reserve space.

Three topics of major importance will be on the program for discussion at the Presidents and Secretaries Conference, April 20, namely:

"Doctors and the Military Situation" (a guest speaker of prominence and who has the latest facts will lead the discussion).

"Medical and Hospital Care for Relief Recipients and Old Age Pensioners" (Mr. Robert Canary, chief, Ohio Division of Social Administration, and a panel, will start the ball rolling).

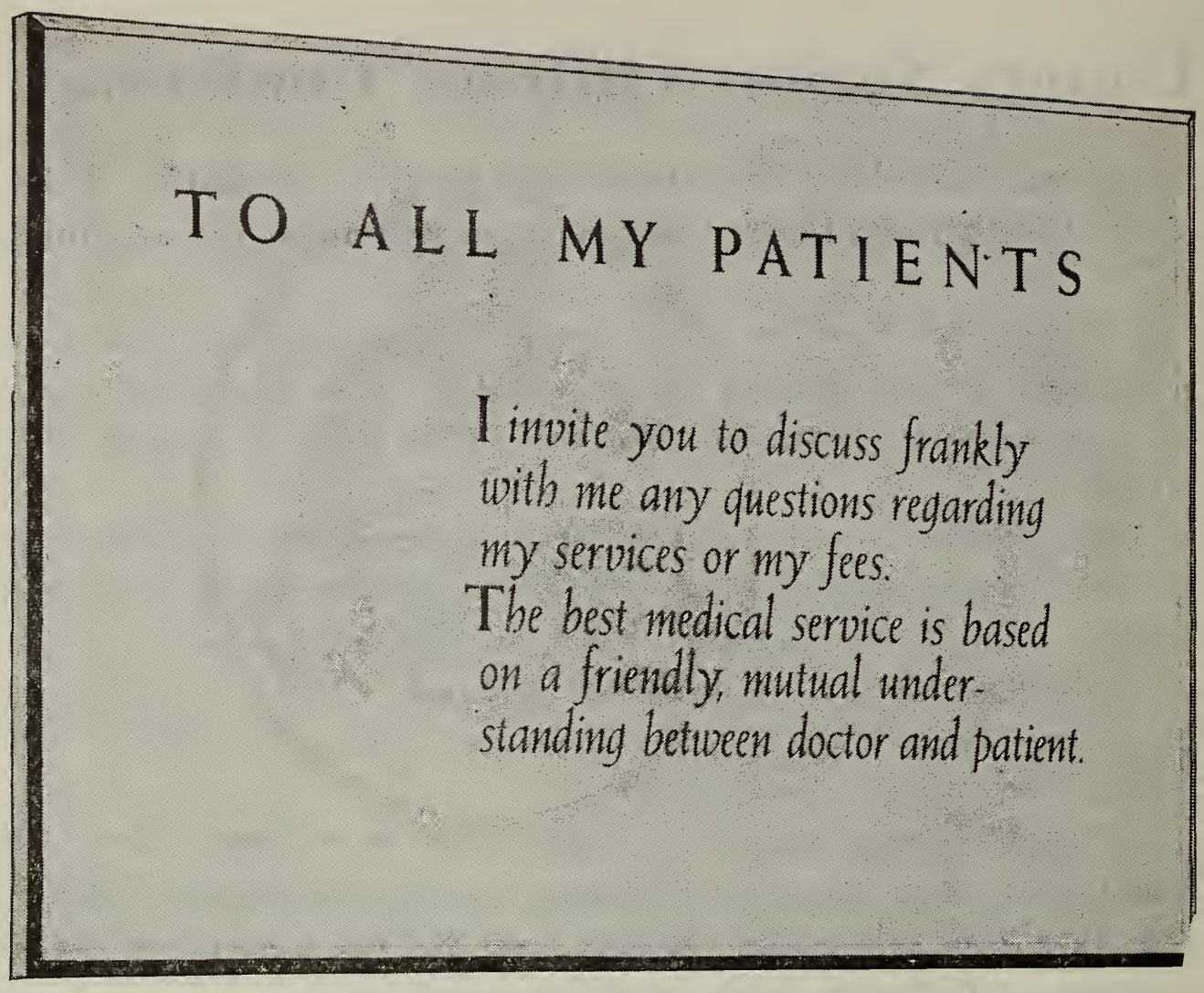
"State and Federal Legislation" (some O.S.M.A. official, armed with the latest facts and predictions, will handle this one).

Obviously, there will be time for questions and answers and general discussion on these and other topics of interest.

The program will start at 1:30 P.M. Officers and committee chairmen of County Medical Societies will be the guests of the State Association at luncheon, starting at 12 Noon. This will be an invitational luncheon.

All members of the State Association who care to attend the conference when it opens at 1:30 P.M. will be welcome. More details on the meeting will be published as soon as certain arrangements have been worked out.

This is solely advanced warning—especially about getting hotel reservations for Monday night, April 20, if you plan to attend. Naturally, the Council hopes that all taking in the Monday conference will stay over for the Annual Meeting, the program for which will appear in the March issue of *The Journal.*



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On the Legislative Front . . .

Ohio General Assembly and Congress Get Off to Flying Starts; Leaders And Health Committee Personnel Picked by Legislature; Bills Discussed

OHIO'S 100th General Assembly and the 83rd Congress got off to flying starts the first week in January.

This article will endeavor to bring members up to date on what had transpired up to press time—January 20.

Ohio's General Assembly convened on Monday, January 5. It started by organizing, naming committees and starting hearings on a number of important pieces of legislation; namely, recodification of the Ohio General Code and appropriations of $8,500,000 for expansion of the prison system—an aftermath of the Ohio Penitentiary fire.

The bill to appropriate money for expansion of the prison system was passed by the House on January 13.

Little other business of any consequence was transacted during the first three weeks of the session as efforts were concentrated on the Code Revision proposal. If that is finally enacted, all bills presented during the session will have to be written to conform to the new chapters, section numbers and uniform wording, specified in the revised code.

SAXBE AND MECHEM HONORED

The House of Representatives organized by electing William Saxbe, Republican, Champaign County, as speaker; Kline L. Roberts, Republican, Franklin County, as majority floor leader and Carl Guess as clerk. The House Democrats elected James J. McGettrick, Cuyahoga County, as minority floor leader.

Senator C. Stanley Mechem, Athens County, was elected president pro tem (Republican floor leader) by the Senate. The Democratic minority elected Senator Joseph Bartunek, Cuyahoga County, as their floor leader. Thomas E. Bateman was re-elected clerk.

If past experience repeats, 50 to 65 bills having a medical and health angle will be introduced. The majority of these measures will, undoubtedly, be referred to the health committees of the House and Senate. Following are the members who will serve on those committees:

HOUSE HEALTH COMMITTEE

Mrs. Carll S. Mundy (R), Lucas-co, Chairman
Harry K. Crowl (R), Montgomery-co
John Hayden (R), Clermont-co
Harold Oyster (R), Washington-co
James S. Simmonds (R), Hamilton-co
J. K. Weaver (R), Huron-co
Howard L. Williams, D.D.S., (R), Trumbull-co
Mrs. Loretta C. Woods (R), Scioto-co
Joseph H. Avellone (D), Cuyahoga-co
Patrick J. Dunn (D), Tuscarawas-co
George M. Hook, Jr., (D), Brown-co
Eugene J. Sawicki (D), Cuyahoga-co

SENATE COMMITTEE ON EDUCATION AND HEALTH

Charles A. Mosher (R), Lorain-co, Chairman
Oakley C. Collins (R), Lawrence-co, Vice-Chairman
Robert A. Pollock (R), Stark-co
Ralph L. Humphrey (R), Ashtabula-co
Fred L. Hoffman (R), Hamilton-co
Ross Pepple (R), Allen-co
Robert R. Shaw (R), Franklin-co
Nicholas P. Bernard (D), Mahoning-co
John T. Corrigan (D), Cuyahoga-co

The powerful **Rules Committees**, which make up the daily calendars and schedule bills for action on the floor, will be composed of the following: **House**—Speaker Saxbe, McGettrick, Roberts, Johnson (Medina), Kirpatrick (Knox), Sours (Summit) and Wallace (Pickaway); **Senate**—Mechem, Bartunek, Moorhead (Muskingum), Sheppard (Summit), Deddens (Hamilton), Ferguson (Guernsey), Pollock (Stark) and Blake (Belmont).

"VOTES MADE BACK HOME"

In a Legislative Bulletin sent on January 8 by the Committee on Legislation of the Ohio State Medical Association to the Presidents, Secretaries and Legislative Chairmen of all County Medical Societies, those local officials were urged to keep in close touch with their Representatives and Senators on medical and health proposals. The following pertinent advice was offered:

"VOTES ARE MADE BACK HOME. MOST LEGISLATORS LOOK TO THEIR PHYSICIAN CONSTITUENTS AND COUNTY MEDICAL SOCIETY FOR FACTS, ADVICE AND GUIDANCE ON MEDICAL AND HEALTH ISSUES. SUCH DATA AND ADVICE SHOULD BE GIVEN TO THEM. USUALLY WHEN A LEGISLATOR GETS OFF FIRST BASE ON MEDICAL AND HEALTH QUESTIONS, IT IS BECAUSE HIS LOCAL PHYSICIANS OR HIS MEDICAL SOCIETY HAVE BEEN ASLEEP AT THE SWITCH. KEEP IN CLOSE TOUCH WITH YOUR LEGISLATOR OR LEGISLATORS. WEEK-END CONFERENCES WITH THEM

AFTER THE SESSION GETS WARMED UP ARE HIGHLY DESIRABLE."

NEW BILLS IN CONGRESS

Health and welfare bills introduced at the opening of the 83rd Congress demonstrate that health subjects are popular with members of Congress. Favorite subject, if number of bills introduced is any criterion, is the proposed amendment to the Constitution prohibiting the U. S. participation in any international agreement adversely affecting the rights of U. S. citizens or otherwise superseding the Constitution. They are generally known as the Bricker Resolution, which was the subject of hearings in the Senate last session but never finally acted on.

Other first day measures included bills (1) similar to Reed-Keogh bill of the 82nd Congress which would permit physicians and other self-employed to defer income tax payments on money paid into pension funds, (2) various medical benefits to veterans, (3) free hospitalization for beneficiaries of Old Age and Survivors Insurance (the Ewing plan of two years ago), (4) a waiver of OASI premiums for the totally and permanently disabled, and (5) hospital and medical care of servicemen's dependents.

AMONG ANTICIPATED PROPOSALS

Other proposals which will be presented to the Congress during the session will include: To re-enact the Doctors' Draft Act, with amendments; to establish a Department of Health, with cabinet status; to increase Federal aid to local public health units; to provide maternity and infant care for dependents of military personnel; to provide Federal aid to medical schools; and, of course, to enact an all-inclusive Federal health and medical plan in some form.

BUDGET FACTS

The outgoing administration's budget proposes that health and welfare expenditures for the fiscal year starting next July 1 continue at about the present rate. The total is $2.7 billion, including Social Security and public assistance payments of approximately $1.4 billion. For purely health programs the breakdown in millions of dollars includes: Federal Security Agency 318, Federal Civil Defense Administration 100, Atomic Energy Commission 26, Veterans Administration 717, National Science Foundation 15 and Bureau of Indian Affairs 22. Included in the FSA total is $75 million (the same as this year) to finance the Hill-Burton hospital construction program.

The incoming Budget director, Joseph M. Dodge, has said there isn't enough time to submit a new budget. Instead, each new cabinet head will go over the budget and send revisions to Congress.

NEW COMMISSION PLANNED

Senator Taft's plan for a **commission** to look into all aspects of federal-state relations, including health and welfare grants, is making progress. A bill authorizing such a commission has been drawn up. President Truman's **State of the Union message** was mainly devoted to international problems; referred to health matters only in two connections, the work of World Health Organization and this country's hospital construction (Hill Burton) since 1946 . . . As anticipated, his budget message urged Congress to give careful consideration to the Magnuson Commission's recommendations.

Dr. Hayman To Head Tufts College School of Medicine

Ohio is losing one of its outstanding physicians and educators with the announcement that Dr. Joseph M. Hayman, Jr., has accepted the post as dean of the Tufts College School of Medicine, Medford, Mass. He also will act as professor of medicine at Tufts and chief physician at New England Center Hospital.



J. M. HAYMAN, JR., M.D.

Dr. Hayman is professor of medicine at Western Reserve University School of Medicine. A brilliant war record during World War II brought him the Legion of Merit for service in the Southwest Pacific, particularly in New Guinea with the well-known Lakeside Unit. Later he was named chief of medicine at Moore General Hospital, Swannanoa, N. C., center for research in tropical diseases.

He left the service as a Colonel and has since toured the Orient twice as consultant for the Army Medical Corps. Dr. Hayman has been on the staff of Western Reserve since 1929 and became professor of medicine in 1948.

Michigan Announces Review Courses for Physicians

The University of Michigan Medical School, Ann Arbor, announced a series of review courses for practicing physicians to be held during the early part of 1953. Additional information may be obtained from Dr. H. H. Cummings, chairman, Department of Postgraduate Medicine, University Hospital, Room 2040, Ann Arbor.

The courses are as follows: Diseases of the Heart, March 16-20; Electrocardiographic Diagnosis, March 23-28; Recent Advances in Therapeutics, March 30-April 2; Diseases of Blood and Blood-Forming Organs, April 6-10; Metabolism and Endocrinology, April 6-10; General Practice, April 13-24; Obstetrics, January 21-24; Gynecology, February 25-28; Ophthalmology, April 20-22; Roentgenology, Diagnostic, April 6-10.



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- labyrinthitis
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SEARLE *Research in the Service of Medicine*

Emergency Call Services . . .

Reports from Sixty-Two County Medical Societies Show That a Program To Help Citizens Get a Doctor in Time of Emergency Is In Effect Locally

SIXTY-TWO County Medical Societies in Ohio have reported to the Columbus Office of the Ohio State Medical Association that there is some organized plan in operation in the county through which residents may secure the services of a physician for emergencies or where the regular family physician cannot be reached.

Establishment of emergency call services has been emphasized in the public relations program of the State Association. The cooperation of all County Medical Societies has been requested. Some of the societies indicated that the matter was under consideration. Others which have not reported may have organized emergency call programs but their names cannot be included in the list until they report to the Columbus Office.

Some of the local programs are carried on through the full-time offices of the local medical society. Most of the programs use a local hospital, or hospitals, as a central contact point. Publicity which has been given to the plan is mentioned in some instances.

The Journal is publishing this information on the plans in effect in counties which have reported in order to show, briefly, how the situations are handled in those areas.

Allen County: Emergency service at both Lima Memorial and St. Rita's Hospitals in Lima with residents on staff in attendance.

Ashland County: Physician on first and second call for surgery, medicine, obstetrics, anesthesis and ENT. Samaritan Hospital operator can reach the above in event of an emergency. Program operates through staff of Samaritan Hospital.

Athens County: No county-wide program for emergency call service. However, the doctors in City of Athens have a Medical Bureau which can reach them at any time or find a substitute. In Nelsonville, the Mount Saint Mary's Hospital has a call service to take care of emergencies.

Belmont County: Bellaire, Martins Ferry and Barnesville Hospitals sponsor an emergency call service. Usually one man serves two weeks twice a year. At least someone is on call at all times at each hospital.

Butler County: The cities of Middletown and Hamilton operate separate emergency call systems through their respective hospitals. The doctors on Middletown hospital staff rotate on 24 hour emergency calls and are available at the hospital. Hamilton has a similar service.

Champaign County: Weekly ad in local newspaper says—"If unable to locate your own doctor, call Mercy Hospital. They will give you the name of the doctor who will take care of all emergencies." The society furnishes the hospital with a roster.

Clark County: Maintains an organized, 24-hour emergency call service, in connection with society offices.

Clinton County: There is a different physician on call every day of the month. His name is obtained by the patient by calling the Clinton Memorial Hospital.

Coshocton County: All members take emergency calls and hospital cases for one week at a time. If he is unable to answer the call, next one in line will take it. Calls are handled through the hospital.

Crawford County: Each doctor rotates to spend a month on emergency calls at the hospital emergency room making himself available at all times during that month.

Cuyahoga County: Maintains an organized, 24-hour emergency call service, in connection with society offices.

Darke County: Sponsored by Darke Co. Medical Society members informally through the Greenville Wayne Hospital. Staff members are on call in rotation for emergencies coming to the hospital. Community can reach their physician or one on service at hospital by calling in to the hospital or coming to the hospital.

Defiance County: Duplicate phone call in local phone directory which directs the one that calls to call the hospital if unable to obtain the doctor called. The hospital will duplicate this call by obtaining another doctor at once.

Delaware County: Doctor who is on for emergencies at the hospital answers any emergency call, especially on Wednesday afternoons when most of the doctors are not in their offices. Article in local paper telling the public about plan.

Erie County: Each of the two hospitals has an emergency call list for medicine and surgery, E. E. N. T. with rotation of doctors on call. This is a staff function at the hospitals.

Fairfield County: Two physicians are on call for emergency accidents and illness cases that come to the hospital. This does not operate for emergency calls in the home.

Fayette County: A rotation emergency service of one week's duration handling all hospital

Announcing

The Fifth Annual Scientific Assembly

of

THE AMERICAN ACADEMY OF GENERAL PRACTICE

at

The Kiel Auditorium, St. Louis, Missouri

March 23-26, 1953

Formal Lecture Program — Fifth Annual Scientific Assembly

HOUR	MONDAY	TUESDAY	WEDNESDAY	THURSDAY
9:00 9:30		**The Physical Examination** Louis A. Kraus, M. D.	**Management of Thyroid Diseases** Richard B. Cattell, M. D.	**Medical Management of Cardiac Emergencies** Thomas Durant, M. D.
9:30 10:00	Registration begins 9:00	**Management of Common Eye Conditions** J. Hewitt Judd, M. D.	**Bleeding Lesions of Colon and Rectum** Robt. W. Bartlett, M. D.	**Diagnosis of 2nd and 3rd Myocardial Infarcts** Chauncey C. Maher, M. D.
10:00 11:00	OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS 9:00	RECESS FOR EXHIBITS		
11:00 11:30		**Cystoscopic Diagnosis** Elmer Hess, M. D.	**Diagnosis and Treatment of Lung Tumors** Cranston W. Holman, M.D.	**Newly Estab. Ranges of Normal Blood Pressure, Hypertension** Arthur M. Master, M. D.
11:30 12:00		**Diagnosis of Common Proctologic Lesions** H. R. Reichman, M. D.	**Antibiotics in Surgery** W. A. Altemeier, M. D.	**Diseases of Stress** Harley E. Cluxton, M. D.
12:00 1:30	Opening of Program and Welcoming Speeches 1:00	LUNCH		
1:30 2:00	**Somatic Types in General Practice** Howard L. Sprague, M. D.	**The G. P. and the Industrial Physician** Earl F. Lutz, M. D.	**Bedside Estimation of Water and Electrolyte Balance** Robt. Elman, M. D.	
2:00 2:30	**Early Problems in Poliomyelitis** Ralph Platou, M. D.	**Industrial Medicine in General Practice** Gradie Rowntree, M. D.	**Useful Medications in Gastroenterology** James L. A. Roth, M. D.	
2:30 3:00	**Rheumatic Fever Problems in Childhood** Arild E. Hansen, M. D.	**Some Quasi-Occupational Diseases** C. D. Selby, M. D.	**Diagnosis, Treatment of Peripheral Vas. Diseases** Meyer Naide, M. D.	ASSEMBLY CLOSES 12:00
3:00 4:00	RECESS FOR EXHIBITS			
4:00 4:30	**Acute Infections of the Pharynx** Robt. Godwin, M. D.	**Spinal Anesthesia** L. F. Schumacher, Jr., M. D.	**New Antihistaminics** David F. Marsh, M. D.	
4:30 5:00	**Heart Disease in the First Year of Life** Robt. A. Lyon, M. D.	**Common Gyn. Problems in General Practice** Walter J. Reich, M. D.	**Diagnostic Problems in Pernicious Anemia** M. Pinson Neal, M. D.	
	EVENING	**CONG. OF DELEGATES DINNER**	**ANNUAL BANQUET**	

and home emergency services in county. A second physician on call to help if first physician swamped.

Franklin County: Maintains an organized, 24-hour emergency call service, in connection with society offices.

Geauga County: Listed as the Physician Call Bureau in the telephone (Chardon) book, the calls are handled by the attendants of Corey Hospital. Each doctor in the county is listed and thereby on call 24 hours a day except when he is signed off by his direction.

Greene County Program is run by the staff of the Greene County Memorial Hospital. Chairman assigns two doctors, one on first, one on second call for each day of the month.

Hamilton County: Maintains an organized, 24-hour emergency call service in connection with society offices.

Hancock County: Emergency cases that do, or will go, or can be convinced they should go to the emergency room at hospital will be seen by the physician on call, but no provision is made for home calls.

Hardin County: One doctor is on call for all emergencies at both hospitals (San Antonio and Hardin Memorial) for one week.

Henry County: The physicians alternate months on emergency call by the Heller Memorial Hospital.

Highland County: Call service handled through the Highland Community Hospital—day or night.

Holmes County: Holmes Co. Memorial Hospital is centrally located and the doctors rotate on emergency call.

Huron County: Cities having hospitals have physician on call for emergencies (Norfolk, New London and Willard Hospitals).

Jackson County: Physicians of Wellston have a Sunday and Holiday program list kept at police station and by telephone operators.

Jefferson County: Emergency calls handled through an emergency program at the Ohio Valley Hospital. A rotating list of physicians is available for emergencies for patients who have no family physician or whose physicians are not available.

Knox County: There are two M. D.'s on emergency call at each of the hospitals—one doctor on first call and the other doctor serving second call or relief. Doctors are rotated.

Lake County: In cooperation with an independent call bureau listed in telephone book as doctors' answering service and sponsored by society.

Lawrence County: Rotation plan—ten doctors. Covers every day of year. Twenty-four hour call hospital phone and emergency room is headquarters.

Licking County: The staff of Newark Hospital which is essentially the same as the Licking Co. Medical Society has a staff member on call at the hospital at all times.

Logan County: Emergency room service at Mary Rutan Hospital, Bellefontaine, in which a physician is on emergency call for two-week periods.

Lorain County: Arrangements have been made at each of the hospitals in Lorain, Oberlin and Elyria whereby a call to such hospital at any time would be given the name of some physician who would respond.

Lucas County: Maintains an organized, 24-hour emergency call service, in connection with society offices.

Mahoning County: Maintains an organized, 24-hour emergency call service, in connection with society offices.

Medina County: At Medina Hospital, doctor on call where emergencies can be treated.

Meigs County: The Meigs General Hospital has a doctor available at all times for hospital cases; not for home calls. Pomeroy and Middleport both have an emergency squad which answers calls when needed or when a doctor is not available.

Miami County: People in Troy and Piqua utilize hospital, post office and hospital telephone exchange for emergency calls.

Montgomery County: Maintains an organized, 24-hour emergency call service, in connection with society offices.

Morrow County: Through the Morrow County Hospital the active staff rotates through emergency call service being "on duty" for one month at a time. Any emergency can be treated there or the physician on emergency is available for other emergencies.

Muskingum County: Two physicians cover emergency calls from Bethesda and Good Samaritan Hospitals in Zanesville for one week on rotating basis.

Ottawa County: Physician on call at local hospital. Days off and vacations, staggered. Local hospital acts as a clearing house on emergency calls.

Pickaway County: Circleville physicians take turns being on call at Berger Hospital for a week at a time; during that week the M. D. on call takes anything that comes in. In addition a medical call bureau is maintained at the hos-

Meat...

and the Therapeutic Value of Adequate Protein

Much evidence can be cited in favor of a high protein intake after surgery, trauma, infection, or burns. In supporting the many anabolic and defense mechanisms of the organism in physiologic stress,[1] high-quality protein—such as that of meat—assumes the status of an important therapeutic agent.[2]

Phagocytic activity,[3] formation of antibodies,[4] and rapid healing of wounds[5] are favorably affected by ample protein nutrition. Remission of peptic ulcer,[6] improved resistance to infectious disease,[4] and maintenance of plasma proteins after surgery[7] are other therapeutic effects attributed to an ample protein intake. In the management of ulcerative colitis, protein represents a primary need.[8] Recent advances in the treatment of extensive burns and of hepatic disease emphasize the value of high protein feedings.[9]

These experimental and clinical findings establish the therapeutic value of high protein intake.[10] To assure therapeutic protein adequacy, the dietary should provide a liberal margin of protein over normal requirements.

Meat is an important source of high-quality protein, containing essential as well as nonessential amino acids. In addition, it supplies significant amounts of B group vitamins and of iron, phosphorus, and other needed minerals.

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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

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pital to locate individual doctors who fail to answer office or home phones.

Portage County: Hospital emergency calls taken by one doctor for two weeks' period, alternating throughout the year. Available at hospital for emergency calls.

Ross County: Rotating emergency duty, every physician in turn on call for a 24-hour period.

Sandusky County: Emergency medical call program working through hospital. Each staff member who is able is on call for one week.

Scioto County: Maintains an organized, 24-hour emergency call service through hospitals.

Seneca County: Mercy Hospital has one man on first call and one man on second call for all specialties. These rotate monthly.

Shelby County: Two doctors are on call at our local hospital to cover any emergency call at all times. Doctors rotate.

Stark County: Maintains an organized, 24-hour emergency call service, in connection with society offices.

Summit County: Maintains an organized, 24-hour emergency call srevice, in connection with society offices.

Trumbull County: Each doctor under age 60, irrespective of specialty status is on call for one full day on a rotational basis. Public was notified of plan by newspaper advertisements and editorial, plus news releases.

Tuscarawas County: Emergency call system is operated by the local hospital staffs—Union Hospital in Dover, Ohio, and Twin City Hospital in Dennison, Ohio. Men on a rotating roster for emergency room and house calls.

Union County: All members of the Union County Medical Society serve on a rotation system. Two doctors serve a period of one week on call and alternate calls through hospital.

Van Wert County: Doctor on call at hospital.

Washington County: Physicians are on call at hospital for emergencies. Each physician has two weeks of service—rotating—one alternate physician on call to replace or substitute if one on call not available. Physician on call to get substitute if he is not available or to be away.

Wayne County: The staff of the Community Hospital rotate and are on emergency call for 24 hours every other two weeks.

Williams County: Emergency plan at the county hospital.

Wood County: Doctors maintain a 24-hour call service at Wood Co. Hospital at Bowling Green and one doctor on first call and one on second call for one week duty.

Wyandot County: Doctors rotate taking emergency calls at Wyandot Memorial Hospital.

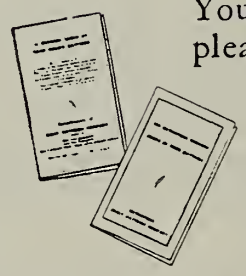


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Use of Immune Globulin . . .

Ohio Department of Health Will Continue Policy of Issuing Globulin For Measles; Present Supply Is Not Adequate for Use in Poliomyelitis

DR. JOHN D. PORTERFIELD, director of the Department of Health, has issued a statement of policy on availability of the Department's supply of immune globulin. The statement, which is given in full in this article, reveals the following points:

Until other arrangements can be established the Department can do little more than continue its present policy of distributing free immune globulin for measles within the limits of its inventory.

Use of immune globulin in infectious hepatitis will be restricted to those occasions where special arrangements have been made with the Division of Communicable Diseases.

Requests for immune globulin for the prevention of paralytic poliomyelitis cannot be honored until a more adequate supply is available.

The Office of Defense Mobilization is in process of setting up on a national basis a special agency for the allocation of available supplies.

The Red Cross has announced that it will step up its blood collections, but has indicated its intent to turn over all supplies of immune globulin to the national allocating authority.

ALLOCATION PLAN IN THE MAKING

A method of allocating gamma globulin on a national basis, because of its restricted supply, will be established soon by a committee appointed by the National Research Council.

Dr. Porterfield, who is secretary of the Conference of State and Territorial Health Officers, is a member of the committee. The job of the committee will be to work out a practical plan for the distribution of the serum through state public health agencies under regulations which will allow the use of a certain portion of the serum for polio and a part for other diseases in which its use has been shown to be effective. The anticipated supply, even under a stepped up Red Cross blood procurement program and with military needs for blood as great as at present, will not be sufficient to permit the use of gamma globulin for immunization of all children who would be potential polio victims.

STATEMENT OF POLICY

Following is the communication issued by Dr. Porterfield to all health commissioners in Ohio:

The recent report by Hammon and co-workers (J. A. M. A., Volume 150, No. 8, October 25, 1952) has shown the effectiveness of Red Cross immune globulin in the prevention or diminution of the paralytic manifestations of poliomyelitis in man. In the dosages used by Hammon, it apparently provides a passive immunity from about the end of the first week after injection for as long as five weeks.

This is an important step in the progress of study of poliomyelitis, providing for the first time a definite measure for the control of the most dreaded aspects of this epidemic disease. However, much remains to be determined in the practical application of this tool and its best use in the control of the disease in the community. Dosages so far known to be effective are relatively large and there is little promise they can be reduced materially.

At the same time immune globulin is an effective tool in the prevention of measles and of infectious hepatitis. Prevention of either of these diseases in selected persons is an important and worth-while measure.

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Immune globulin is produced only by the fractionization of human blood. Its supply, therefore, is limited by the availability of blood and the capacity of fractionization plants. Both of these factors are being augmented as rapidly as possible, but for at least the next nine months there will be available only a small portion of the amount of immune globulin needed and a much smaller portion of the amount demanded for control of the three diseases named.

Immune globulin is, then, a vital material in short supply. In the very near future the Office of Defense Mobilization will be charged with the allocation of available supplies. The American Red Cross, the largest source of immune globulin, has indicated its intent to turn over all its supplies of this material to the national allocating authority. Very little, if any, will be obtainable otherwise.

The allocating authority will operate under a policy to be developed by a special panel and will undoubtedly make its distribution through state health departments. The basic principle of the distribution policy will be to do the greatest good for the greatest number with available resources. The cooperation of all health departments, of practicing physicians, and of the public will be necessary to achieve this principle.

URGES COOPERATION

Until these arrangements have been established, the Ohio Department of Health will con-



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CLARIFICATION OF PROVISION FOR EXEMPTION FROM STATE DUES: TO BE ELIGIBLE, PHYSICIAN MUST BE RETIRED FROM PRACTICE

There appears to be some confusion among County Society Secretaries and older members of the State Association regarding the new By-Laws which became effective January 1, 1953, providing for the waiver of State Association membership dues for those *who have retired* from active practice.

A physician who retires from active practice, or has been retired from active practice, because of age or disability, is eligible to membership in the Ohio State Medical Association without the payment of State Association dues, providing he was a member in good standing of the State Association at the time of retirement.

Exemption from payment of state dues must be requested by the physician and must be approved in writing by the Secretary-Treasurer of the County Medical Society involved. **Should a physician subsequently resume active practice, the exemption from payment of dues will automatically expire.**

The basic factor to be considered is: Retirement from active practice.

For example: If a physician who is 45 years of age is forced to retire because of a physical or mental disability, he *would be* eligible for waiver of State dues. On the other hand, a physician 75 or 80 years of age who is still in active practice *would not* be eligible for waiver of dues.

The Ohio State Medical Association provision should not be confused with the policy of the A. M. A. which automatically grants waiver of dues to any member of the State Association, *whether active or retired,* on the January 1 following his 70th birthday. The A. M. A. will waive dues also for any O. S. M. A. member, regardless of his age, whose State dues are being waived because of retirement from active practice. ***Under either policy, the physician must be a member of the Ohio State Medical Association either through payment or waiver of state dues, in order to be exempted from A. M. A. dues.***

tinue to distribute free immune globulin for measles in accordance with its existing policy within the limits of its inventory. Since this has been greatly reduced, health commissioners are requested to do the following things:

1. Advise this office, Ohio Department of Health, of your present immune globulin inventory together with information as to your average monthly distribution over the past six months.

2. When more immune globulin is needed, order only those amounts which will be required for a month's usage.

3. Urge the physicians whom you supply to restrict usage to the prevention of measles in those individuals where there are valid medical reasons for its prevention.

No requests for immune globulin for the prevention of paralytic poliomyelitis will be honored at the present time. Use in infectious hepatitis will be restricted to those occasions where special arrangements have been made with the Division of Communicable Diseases.

Your continued cooperation in this important program will be appreciated. Further advice will be provided as quickly as it is determined.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association through December 31, 1952. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ERIE COUNTY

Spencer, David M., Sandusky

MAHONING COUNTY

Beynon, David E., Youngstown

Cestone, Patrick B., Youngstown

Shorr, Henry L., Youngstown

RICHLAND COUNTY

Lerro, Sam A., Mansfield

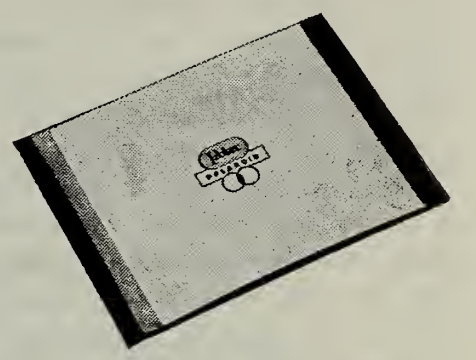
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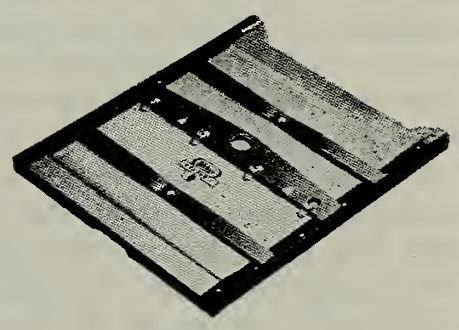
You've probably already heard of the "one-minute" Picker-Polaroid radiograph. Introduced a little over a year ago, this dramatic development was immediately accepted by the Armed Services which requisitioned the entire output for military needs. Ever since, we have been struggling to increase production to the point where parallel civilian needs could at least be partly met. That point has now been reached. Limited quantities are becoming available to civilian users.

The Picker-Polaroid system is an adaptation to radiography of the self-development principle of the Polaroid Land Camera. The whole job takes only a minute . . . can be done in broad daylight . . . needs no darkroom, no solutions, no dryer. It is all incredibly simple and quick: (a) you load the cassette (b) make the exposure (c) put the cassette in the automatic processing box. Wait sixty seconds: open the box and there's your finished radiograph . . . flat, dry, ready for use. Its speed and convenience have already proven invaluable in the operating room for hip-pinning and similar procedures; for emergency hospital admissions, for work with portable and mobile x-ray units.

Since quantities are still limited, those wishing to obtain Picker-Polaroid equipment supplies would do well to communicate at once with either their local Picker office, or with Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.



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Need W.C. Claim Number?...

Here's A Procedure Used by Some Physicians Successfully To Secure Data on C-3 Claims So They Can Maintain Record on Status of Each Case

ONE of the problems which confront physicians in the handling of Workmen's Compensation cases is keeping track of C-3 claims (medical only). Under the present procedure, C-3 blanks, after being filled out by the attending physician, are sent to the employer for review and signature. The employer then is expected to file the claim with the State Industrial Commission where it is given a claim number and processed.

The problem which arises in some instances is caused by failure of the employer to file the claim or delay by him in filing it. The physician has no way of knowing when the claim is filed —if it is. He is handicapped in carrying on correspondence with the Commission as he is not notified of the number given the claim. The employer is notified of the claim number so the physician might eventually secure the number from the employer. However, this is not always practical.

It has been suggested to the Commission repeatedly that it send the claim number of each C-3 claim to the physician in addition to the employer. The Commission's reply has been that it cannot do this because of the additional personnel which would be required and because of the additional expense involved.

A number of physicians who handle a considerable number of C-3 claims in the course of a year have found a solution to this question. Their procedure is as follows and is offered as a suggestion to other physicians:

When the physician sends the C-3 form to the employer, he attaches to it, a self-addressed postcard, carrying a two-cent stamp (usually a regular government two-cent card), with wording on the other side of the card as shown in the sample below.

Some of the cards are printed in black and red, the words "Attention Employer" and "Attention, Industrial Commission," printed in red for emphasis.

The claimant's name, the employer's name and the date of the injury are typed on the card by the physician.

When the Commission receives a C-3 form to which one of these cards is attached, the clerk stamping claim numbers on the forms received that day, stamps the claim number on the postcard and at the end of the day, mails the cards.

This procedure lets the physician know that the employer has filed the claim, when it was filed and the number given to the claim. He can then keep an up-to-date record in his own office and later, if he does not receive a check for services rendered within a reasonable time, he can contact the Commission and refer to the claim by number—an important point as it is difficult for the Commission to locate a claim and to answer correspondence about it unless the claim number is known.

Physicians who have adopted this plan say it works. Try it out. Those handling incoming claims at the Commission's office will cooperate by stamping the number of each claim on each postcard attached and mailing such cards to the attending physicians. Don't overlook these important items: **The card must be self-addressed, must carry two-cents postage and must carry the name of the claimant.** The Commission cannot address the cards or affix postage. Unless the claimant is named, the card is of no value to the physician.

ATTENTION EMPLOYER

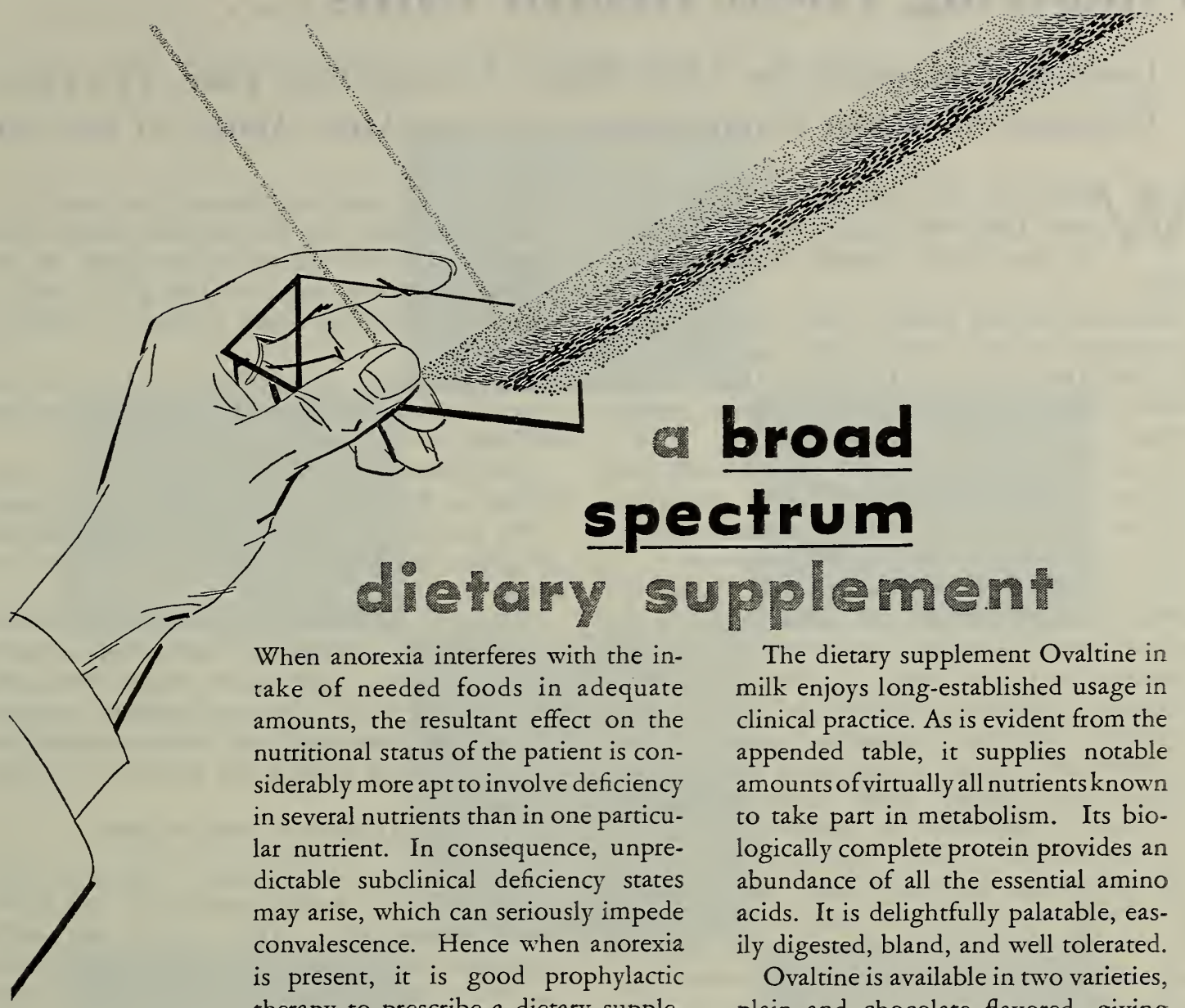
PLEASE LEAVE THIS CARD ATTACHED TO FORM C-3 WHEN FORWARDING SAME TO THE INDUSTRIAL COMMISSION

Claimant's Name

Employer's Name

Date of Injury

Attention Industrial Commission	Claim Number Allotted →	
PLEASE INSERT CLAIM NUMBER ALLOTTED AND RETURN		



a broad spectrum dietary supplement

When anorexia interferes with the intake of needed foods in adequate amounts, the resultant effect on the nutritional status of the patient is considerably more apt to involve deficiency in several nutrients than in one particular nutrient. In consequence, unpredictable subclinical deficiency states may arise, which can seriously impede convalescence. Hence when anorexia is present, it is good prophylactic therapy to prescribe a dietary supplement of broad nutrient spectrum, capable of improving the intake of virtually all indispensable nutrients.

The dietary supplement Ovaltine in milk enjoys long-established usage in clinical practice. As is evident from the appended table, it supplies notable amounts of virtually all nutrients known to take part in metabolism. Its biologically complete protein provides an abundance of all the essential amino acids. It is delightfully palatable, easily digested, bland, and well tolerated.

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*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete) . . . . . 32 Gm.
*CARBOHYDRATE . . . . . 65 Gm.
*LIPIDS . . . . . 30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

Financing Local Health Units . . .

Local Appropriations for Local Needs Average Less Than Two-Thirds Estimated Minimum Requirements; in Some Areas About 40 Per Cent

WHAT was the score during the calendar year 1952 with respect to the financing of local public health departments in Ohio?

Some interesting angles of this question were enumerated by Mr. Jesse Drake, statistician of the Ohio Department of Health, to Ohio's health commissioners at one of their recent get-togethers.

The following data are from Mr. Drake's talk and are presented here to give Ohio physicians a better understanding of the financial picture—often plight—of the local health agencies.

One of the most perplexing tasks facing the administrators of local health departments is the preparation of a budget for a fiscal period which begins three to six months in the future. This problem is further complicated by the fact that increasing costs and expanding programs must be anticipated, yet the budget must be fairly consistent with previous funds made available to the health department for expenditure.

Many local health departments in order to provide needed and requested public health services have found it necessary to look to other sources for revenue, from such agencies as the board of education, county commissioner, tuberculosis association, cancer society, and others. In some instances, a portion of the program must depend on fees received for the issuance of permits.

In the calendar year 1952, the total funds available to all local health departments in Ohio was $8,377,816.00.

Of this amount, $7,007,497.00 or 83.6 per cent of the total came from local appropriations. The balance, $397,019.00 or 4.7 per cent of the total, was derived from such agencies as the board of education, tuberculosis association, cancer society, and others. Eight per cent of the total, $666,-300.00, represented Federal grant-in-aid payments made to full time health departments and the balance of $307,000.00 or 3.7 per cent was derived from the state subsidy paid to all local health departments.

The average per capita appropriation for all local health departments in 1952 was $.95. The average per capita appropriation for the year 1950 was $.74, an increase of $.21 per capita from the year 1950 to 1952.

APPROPRIATIONS VARY

Some areas of the state are better off than others as far as appropriations to local health departments are concerned. Using the areas served by the state department's five district offices as examples, the average per capita appropriation for all health departments in the Southwest District was presently $1.17, which is somewhat above the state average of $.95 per capita.

The Northeast and Northwest Districts had a per capita appropriation of $.95 or exactly the same as the state average.

The Central District had a per capita appropriation of $.86 which is below the state average.

The Southeast District had a per capita appropriation of $.61 which is well below the state average.

Full-time participating local health departments had an average per capita appropriation of $1.04, which is slightly above the state average of $.95 while non-participating part-time health departments had a per capita appropriation of $.60 which is quite a bit less than the state average.

VARIATION BY TYPE OF DEPT.

The per capita appropriation varies considerably between city health departments and county health departments. The average per capita appropriation for all city health departments was $1.10 as compared to an average per capita appropriation of $.70 for all county health departments.

The average per capita appropriation for all participating full-time city health departments was $1.20 as compared to an average per capita appropriation of $.75 for participating full-time county health departments.

For non-participating part time county health departments, the per capita appropriation was $.55 as compared to a per capita appropriation of $.64 for non-participating part time city health departments.

For the period 1950 through 1952 the average per capita appropriation for all full time participating departments has risen from $.82 in 1950 to $.93 in 1951 and to $1.04 in 1952.

The average per capita appropriation for all non-participating part time health departments for the same period has risen from $.53 in 1950 to $.74 in 1951, and slumped to $.60 in 1952.

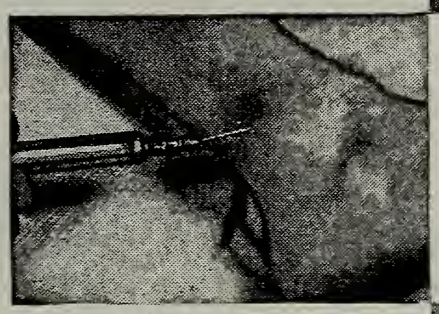
Although there was an increase in appropriations for local public health agencies, the increase was just about equal to the increased costs of supplies and services as a result of inflation.

Ohio still is far away from the goal of $1.50 per capita for public health services.

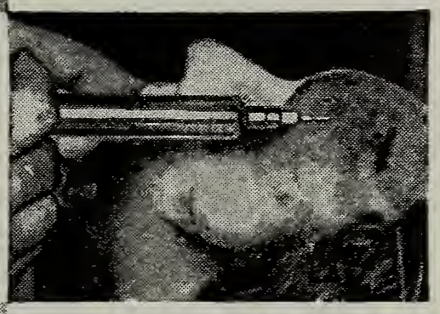
WYDASE HAS MANY IMPORTANT ADVANTAGES IN EVERYDAY MEDICAL PRACTICE



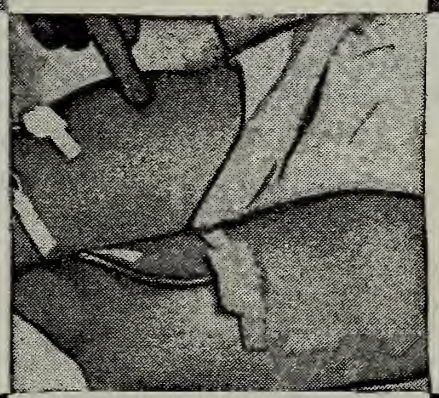
REDUCTION OF SIMPLE FRACTURES



TREATMENT OF SPRAINS



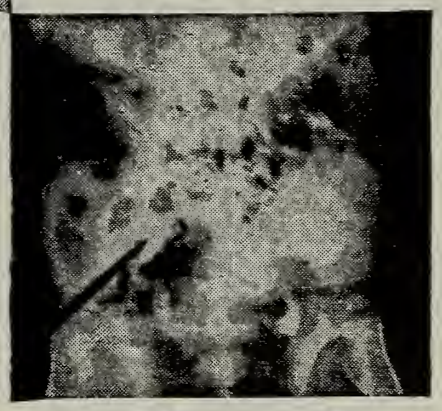
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New Poor Relief Plan . . .

Report of Committee of Relief Directors Recommends Changes In Ways Of Financing and Distributing Hospital and Medical Services to Indigents

ONE of the important questions which will be considered by the Ohio General Assembly, now in session, is legislation to improve the administration and operation of the Ohio Poor Relief Law.

It is possible that a bill may be introduced to decentralize the administration of poor relief activities by making it solely a county function. Also, it has been reported that legislation will be proposed to establish a different procedure for hospital and medical benefits.

For these reasons, a recent report of the Hospital Committee of the Ohio Welfare and Relief Directors' Association on the subject of hospital and medical care is of particular interest. The committee making the report consisted of Donald G. Swallow, Cincinnati, chairman, A. J. Scolastice, St. Clairsville, Henrietta Hill, Bryan, Warren L. Harding, Hamilton, Leo Rinehart, Athens, and Denver White, Lancaster.

TEXT OF REPORT

The report, as published in *Public Welfare In Ohio Today*, official magazine of the Ohio Department of Public Welfare, was as follows:

Subject: Report of Committee on Hospitalization and Medical Care in Ohio.

The Committee appointed by the Association has met on six occasions. Some of the more important considerations underlying our conclusions are:

1. That local Welfare and Relief agencies should be in a position to bargain freely as purchasers of services at a reasonable and fair expense of public funds.
2. That any plan must be fair and equitable to all hospitals concerned.
3. That any eventually adopted plan must be flexible to meet the varying needs of the counties throughout the State.
4. That a sound plan must safeguard against underwriting any of the costs of inefficient administration in either hospitals or local administering agencies.
5. That there is a duty to the citizens of Ohio to consider and explore all possible financial resources that may lend to a sound financial basis, intelligent planning, and effective administration of hospitalization and medical care to welfare cases.

HOSPITALIZATION OF WELFARE CASES

During the past several months caseloads of the various Public Assistance Programs of Ohio have shown a steady marked decrease. Within the General Relief Program alone the total expended for assistance, excluding medical and hospital payments, decreased $6,400,000 from 1950 to 1951. However, the expenditures for hospitalization and medical care continued to increase with $5,312,628.34 or 28.4 per cent of the 1951 total outlay of relief funds going for hospitalization and medical care. In 1950 such expenditure represented 23 per cent of the total expended.

A question which arises at this point: Should there be some correlation between the decrease in expenditures for other public assistance needs and the amount expended for hospitalization?

Paraphrasing the law of Ohio "Eligibility for hospitalization is based upon financial need (the same as eligibility for all other assistance items and services). Eligibility is determined upon a budgetary basis taking into account the income and resources of the recipient."

It would be unreasonable to contend that operating costs of hospitals have not increased, as the cost per case of furnishing maintenance and services to recipients have increased due to the same inflationary forces. Granting that costs may have increased more for hospitals, it should not be assumed however, that the trend of expenditure for these items should vary indirectly. That is:

The necessity of payment for indigent hospitalization from poor relief funds should have a fairly direct relation to the necessity of payment for food, clothing, and shelter from poor relief

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W. W. DANGELEISEN, M. D., *Medical Director*

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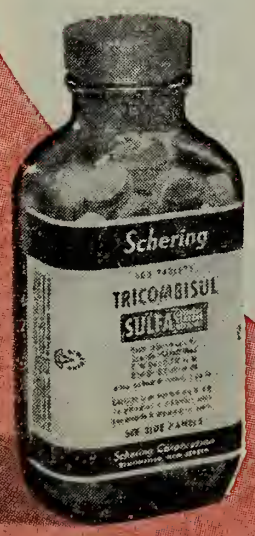
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funds. (Barring an epidemic or catastrophe of course.)

The trend of expenditures for these items from public funds has in past years paralleled quite closely the trend of unemployment. Expenditures for home assistance today reflects this pattern, hospitalization expenditures do not.

WHY ARE COSTS HIGH?

There are many reasons and an equally large number of explanations as to why costs of hospitalization for welfare cases are high. There are also differences of opinion (apparently equally valid) concerning some of the basic reasons for high costs. (The information is available relative to these various views but for brevity is not included in this report.)

The genesis of the committee's consideration of the cost aspect was to obtain as much accurate cogent factual information as was available. Data was obtained from State agencies, local agencies, and hospitals. It was compiled, analyzed, and discussed with persons of considerable knowledge and ability in the field of hospital administration and finance. Herewith are two principal observations of this Committee:

1. The average length of stay of welfare cases is excessive.
2. The governmental reimbursable per diem rate is not a realistic cost basis.

AVERAGE LENGTH OF STAY

The average length of stay of welfare cases is approximately twice as long as the average length of stay of all cases in the general hospitals of Ohio. The latest figures compiled by the Ohio Hospital Association give the average length of stay for all cases as 7.9 days. Blue Cross cases average around 7 days stay. In 8,087 welfare cases analyzed the average number of days each was hospitalized was 15.6. No one familiar with the facts would contend that welfare cases should have as short a stay in the hospital as the average case or that covered by Blue Cross; however, the span between these averages is so large that a plan must be devised to reduce the time spent in hospitals by welfare cases. Reduction of one day would save $400,000.00 to $500,000.00 annually.

GOVERNMENTAL REIMBURSABLE RATE

The so-called per diem cost rate is widely used in Ohio as a basis for payment to hospitals. It is computed by dividing the total hospital expenses for in-patient treatment by the number of adult in-patient days service. Many hospital administrators and members of their boards are under the impression that such a rate is the actual cost rate and that reimbursement should be upon this basis. In some instances, hospital board members have exerted considerable pressures upon Welfare Departments and County Commissioners for acceptance of the reimbursable rate. Departments expending public funds for hospitalization should not be forced to pay at a rate in excess of actual costs.

The rate exceeds cost largely because it contains sizeable amounts for depreciation either in the optional form of 6 per cent of the annual operating cost, or in the form of the original cost of the buildings, fixtures, and equipment prorated over the period of the estimated life of the buildings, fixtures and equipment.

Any rate containing depreciation should be rejected. From the accounting viewpoint, hospitals do not actually fund or set aside any money for replacement. It should also be rejected from the standpoint of public policy.

Hospital buildings, fixtures, and equipment do depreciate; however, the concept of charging depreciation as an annual expense relates to properties of private enterprises, wherein investments are represented by continuing capital obligations in the form of stocks and shares. It involves the actual annual funding from earnings the amount charged to depreciation.

Neither public nor private hospitals are constructed or paid for by the selling of stock. The usual arrangement is that of selling bonds in the case of public hospitals and by various forms of gifts in the case of private hospitals. There are no equity capital obligations, shares, stocks, right to dividends, earnings to be divided, or investor obligations to be secured.

Another important reason for not using the reimbursable rate is because of the extreme length of stay of welfare cases. As a general rule the first few days in a hospital entail the greatest expenditures—this is the period when tests, x-rays, laboratory services, etc., are administered.

Where there is a large group of cases having longer than average stay in a hospital, a Welfare Department contracting for this group at the per diem rate is paying a disproportionate share of the total expense which is concentrated in the first few days, and is not given the advantage of reduced per diem expenditures for later days of hospitalization.

THE HOSPITAL CARE PLAN

The feasibility of extending Hospital Care (Blue Cross) to Public Assistance cases was studied and is recommended on a trial basis.

This plan would function primarily in the following manner: Local welfare agencies would continue to determine eligibility and carry out all other tasks now being performed except, the contracting with individual hospitals, the receipt and processing of bills, and the actual payment of bills. These latter tasks would be handled by a non-profit Hospital Care Corporation. Payment to Hospital Care would be in the form of reimbursement on the basis of actual cost.

This Plan should result in reduced expenditures


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21A52

due to a shorter length of stay and a lower cost per day. Each recipient-patient would be identified to hospital staffs and doctors as a Hospital Care Subscriber not as a welfare case. Certain contractual advantages enjoyed by hospital Care Corporations, and not now available to welfare agencies, would also be gained through such a plan.

A committee was appointed by the Blue Cross organizations in Ohio to study such a plan. Blue Cross officials have stated they are definitely interested and will cooperate if practical and legal procedures can be devised.

THE TRUST OR POOL PLAN

The trust or pool plan would bring into Ohio an estimated $3,000,000.00 in Federal funds for hospitalization and medical care.

This plan was made possible by the 1950 amendments to the Social Security Act. Authority for the State to obtain Federal reimbursement is contained in Federal Security Agency Letters Nos. 161 and 169. The theory of the pool plan is to use Federal funds to the maximum extent possible to supplement local and state funds for hospitalization and medical care. Quoting from Federal Security Agency State Letter No. 161:

"Payments into the pooled fund, established under an approved plan as provided herein, are subject to Federal participation as assistance expenditures for medical care in behalf of public assistance recipients. Federal financial participation may be claimed in the monthly payment made into the fund to the extent that such payment added to any other assistance paid to or in behalf of the individual during that month does not exceed the monthly Federal maximums on individual payments for old-age assistance, aid to dependent children, aid to blind, and aid to the permanently and totally disabled."

Considerable flexibility is possible. A pool fund may be state-wide or limited to recipients of a given geographical area, one or all public assistance categories may be included, and payments may be made either directly to vendors or through group plans such as Blue Cross, County Medical Societies, etc.

The Association should request the State Welfare Department to seek the assistance of the United States and Ohio Public Health Services, the United States and Ohio Bureaus of Rehabilitation, and the United States Bureau of Public Assistance to study this plan's application in Ohio. The following states now have the pool plan functioning; New Hampshire, Connecticut, West Virginia, and New Mexico.

SPECIFIC RECOMMENDATIONS

1. A contract for indigent hospitalization should not exceed 90 per cent of the governmental reimbursable per diem costs as now compiled.
2. The contract rate at 90 per cent should apply only to the first seven days of hospitalization. The next 14 days should be at a rate reduced by $3.00 per day and a further reduction of $3.00 for each day over a total of 21 days.
3. Legislation permissive in nature to permit establishment of the pool fund in Ohio for hospitalization and medical care.
4. Legislation permissive in nature to permit contracting with non-profit organizations such as the Blue Cross Corporation.
5. Legislation requiring the reimbursable cost figures prepared by hospital to be audited and approved by the State Department of Public Welfare or some equally responsible governmental department.
6. Legislation requiring that all hospital records concerning welfare cases be accessible to state and local welfare agencies. Specifically the records concerning debits and credits for individual recipient-patients.
7. Legislation to the effect that relief funds are not to be used for Aid for Aged cases.
8. Request the State Welfare Department to thoroughly study the Pool Plan for hospitalization and medical care in Ohio.

If you are moving to a new location or for other reason plan to change your address, please notify the Headquarters Office as early as possible so that your copy of *The Journal* and other mail may be sent to you without delay.

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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SOME OBJECTIVES FOR THIS YEAR

It's not too late for some good New Year resolutions. So, we suggest that the membership of the Ohio State Medical Association and its 88 County Medical Societies adopt as 1953 objectives, the following constructive recommendations recently issued by Dr. Louis H. Bauer, president of the A. M. A., and which, if made effective, would accomplish more in the way of improved health and medical services than all of the reports of all of the commissions which have ever labored over this question, and without regimentation and extravagance:

1. Work with rural communities to establish facilities for physicians, so that we shall have a better distribution of physicians.
2. See that good medical care for the indigent is available everywhere just as it is in some states.
3. Extend public health coverage to areas lacking it.
4. Develop plans for the care of the chronic invalid.
5. Expand our voluntary insurance program, not only to cover more persons, but to cover those over age 65 and those suffering from illness of long duration.
6. Clean our own house, by disciplining those physicians who are tarnishing the reputation of the whole profession by their unethical acts of overcharging, accepting kick-backs, and making commercial arrangements with pharmacists.
7. See that the public is protected so that they can always obtain the services of physicians.
8. Revitalize our county societies and make them leaders in their communities in all health matters.
9. Inculcate the newly trained physicians in the tradition and ethics of medicine.

PLANS DESIGNED TO WHIP NURSE SHORTAGE PROBLEM

Hospitals are searching for practical plans designed to whip the nurse shortage. Stories carried recently in Cleveland newspapers may contain the solution to part of the problem.

Huron Road Hospital announced that its year-old plan of providing nurses' internships, with pay, is increasing its supply of nurses. The plan makes the student nurse an intern nurse in her third year. She goes on floor duty and is paid $100 a month. After her third year she can take the state board examinations. Enrollment has almost doubled.

The Frances Payne Bolton School of Nursing, Western Reserve University, announced a plan whereby tuition and maintenance is paid by the University Hospitals, with which the school of nursing is affiliated, if the student nurse agrees to work at general hospital nursing duties for one year following her graduation. The subsidy for the 32-months course will be cancelled after the student has concluded the year's work in the hospital after graduation. She will be paid at prevailing salary rates during that year.

Hospitals confronted with the shortage of nurses problem would do well to investigate these two Cleveland programs.

IKE IS RIGHT; HAVE YOU MADE YOUR CONTRIBUTION?

President Eisenhower has the right idea. In a statement endorsing the National Fund for Medical Education, to which the American Medical Education Foundation of the A. M. A. is contributing, General Eisenhower said:

"Private support of higher education in America is fundamental to the democratic tradition. American business must assume a greater share of the operating costs of our institutions or they shall have no recourse but to Federal subsidy—a perilous alternative.

"The nation's 79 medical schools are the keystones of national health and prime factors in our ability to maintain production levels and man our armed services.

"They must not be prevented, because of financial stress, from meeting these responsibilities."

Eisenhower is one of the founders of the national fund.

Have you made your contribution about which Dr. H. M. Clodfelter, President of the Ohio State Medical Association, wrote you recently?

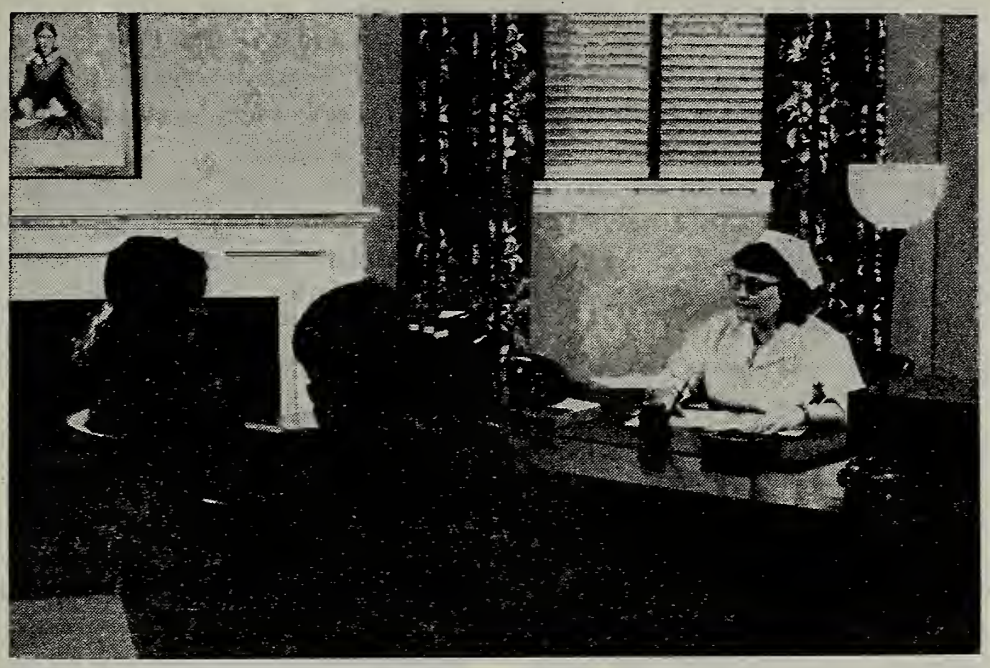
Better think it over, if you haven't. Ike has the right idea.

SENSIBLE ATTITUDE ON GAMMA GLOBULIN DEMANDED

The attention of all readers of *The Journal* is directed to the statement by Dr. John D. Porterfield, state director of health, on page 152, regarding gamma globulin.

This subject has received widespread publicity, first, because the product is being used on an

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A full time course. In Obstetrics: Lectures; pre-natal clinics; witnessing normal and operative deliveries; operative obstetrics (manikin). In Gynecology: Lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Anesthesia. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

UROLOGY

A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the Ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as prostatic resection.

PROCTOLOGY AND GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver; attendance at departmental and general conferences.

FOR INFORMATION ABOUT THESE AND OTHER COURSES ADDRESS—
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experimental basis in polio cases, with some success, and, second, because the Red Cross has announced a speed up in its blood procurement program in order to increase the supply of gamma globulin.

The problem which confronts all at the moment is: How to produce enough gamma globulin to meet anticipated demand?

There appears to be no possibility of solving that problem in the immediate future. For that reason a plan to place rigid controls on the distribution of the limited supply is being worked out.

Ohio physicians should cooperate with the Ohio Department of Health by adhering closely to the procedure outlined in the Porterfield statement. Moreover, they should give their cooperation to procedures which will be announced soon for making available some of the product for polio cases **under certain conditions.**

If the public becomes panicky and demands that gamma globulin be used solely for polio, there will be none for the treatment of measles and several other diseases against which it has been used effectively.

Physicians should be prepared to point out to their patients why controls have had to be applied; why it would be foolish to exhaust the scarce supply by using it exclusively for the treatment of polio; and why a supply must be held back to be used for other diseases in which human life is involved as well.

YOU'RE NOT REQUIRED TO GET SPECIAL AUTO TAG

A few members have written to the Columbus Office stating that they don't believe the new law permitting physicians to secure an automobile license plate with the word "Physician" on it is so hot.

Some of the letters point out that such a tag is nothing but an invitation to a narcotic addict to break into the physician's car. Others say that the tag will attract undue attention to the physician's car and involve him in nuisance types of cases.

In our opinion, these points are valid. The Ohio State Medical Association did not ask for, nor did it sponsor, the amendment authorizing the issuance of these special tags. It was not consulted before the amendment was introduced. It fails to see any real need for such a law.

However, there is one thing about this law which is commendatory. **It is not compulsory.** Therefore, any physician who doesn't want the special tag, for one reason or another, doesn't have to purchase it. There is reason to believe that no physician will offend the State Division of Motor Vehicles if he decides against ordering the special plate.

Do You Know? . . .

When all of the records are in, Ohio will have established a new high in births for 1952, Dr. John D. Porterfield, director of the Ohio Department of Health, predicted on the basis of available records. The previous high was 200,080 recorded in 1951.

* * *

Dr. Arthur G. King, Cincinnati, has been designated chairman of local arrangements for the Second Clinical Session of the American Academy of Obstetrics and Gynecology to be held at the Netherland Plaza Hotel, Cincinnati, December 14-16, 1953. Program chairman is Dr. Andrew J. Marchetti, Washington, D.C.

* * *

Dr. Peter J. Volpe, former Ohio practitioner, and recently manager of the Veterans Administration Hospital at Aspinwall, Pa., has been named manager of the V. A. 3,092-bed general hospital at Hines, Ill. Dr. Volpe practiced medicine in Columbus before World War II and from 1947 to 1949 was stationed in Columbus as medical director of the V. A. Branch Office.

* * *

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, addressed a meeting of the Marion Rotary Club in January, on the subject, "Health Is Your Business."

* * *

Dr. Robert W. Heinle, Cleveland, is co-author of a special article on "Control of U. S. P. Anti-Anemia Preparations," which appeared in the January 3 issue of *The Journal of the A. M. A.* The article is a report of the U. S. Pharmacopeia Anti-Anemia Preparations Advisory Board, from which Dr. Heinle recently resigned as chairman.

* * *

Dr. E. Herndon Hudson, director of the Ohio University Health Center, Athens, has been awarded a U. S. Public Health Service grant to prepare an illustrated monograph on bejel, a form of endemic nonvenereal syphilis found among the Arabs in the Middle East. He will assemble and analyze material accumulated during 12 years in Syria and while serving under the World Health Organization in Iraq in 1950-1951. Bejel was first described by Dr. Hudson in 1924.

* * *

Dr. O. P. Kimball, Cleveland, consultant to the World Health Organization on endemic goiter, in December went to London, England, to meet with the WHO Section on Nutrition and act as chairman of the study group for the prevention of goiter.

* * *

George H. Saville, public relations director for the Ohio State Medical Association, recently was reelected to the Board of Directors of the Public Relations Society of America at its fifth annual conference in Washington.

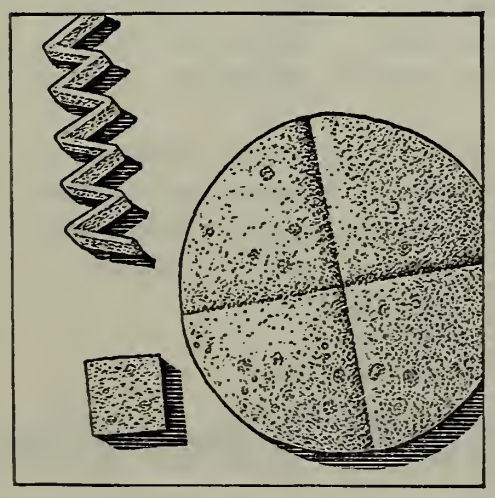
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Ohio Medical Indemnity . . .

Additional Contract Carrying Higher Indemnities Now Offered by Company; Total Enrollment Now 1,400,000, Gain of 242,000 in 1952

OHIO Medical Indemnity, Inc., the Blue Shield Plan sponsored by the Ohio State Medical Association, has announced the introduction of a new subscriber contract.

The new contract, known as "Preferred Contract," will provide any subscriber purchasing it, with higher surgical benefits. An important additional benefit in the "Preferred Contract" is the provision for anesthesia indemnities when administered by a physician.

Dr. L. Howard Schriver, president of Ohio Medical Indemnity, in announcing this contract, stressed that the "Standard Contract" will be retained. All groups enrolled in Ohio Medical and are covered under the "Standard Contract" will be advised of the availability of the new "Preferred Contract." They will have their choice of transferring to the new contract or retaining their present "Standard Contract."

The rates for the "Preferred Contract" are $1.00 monthly for the individual, and $3.00 monthly for the family. Present rates for the "Standard Contract" are $.60 monthly for the individual, and $1.90 monthly for the family.

The new contract is the result of months of study. Dr. Schriver pointed out that the new schedule of indemnities provided by the "Preferred Contract" is not a flat increase of all items in the schedule of the contract which has been offered, but a determined effort to adjust the schedule of indemnities to prevailing charges for surgical services. Consequently, he stated, some of the items in the schedule have been increased ten per cent, while some others warranted an increase of one hundred per cent to accomplish this objective.

HIGHER INDEMNITY

The highest indemnity under the new contract for any one operation is $300. This amount will be paid for pneumonectomy, gastrectomy, and other extensive procedures. The indemnity for tonsillectomy will be $40 for children under 12, and $60 for age 12 and over. Hemorrhoidectomy, internal, will be $100 and herniotomy, $100 for unilateral; $150 for bilateral. Appendectomy will be $125 and dilatation and curettage will be $40.

The anesthesia indemnity is determined by the amount paid under the surgical portion of the contract. An anesthesia schedule will appear in the subscriber's contract so that the subscriber will know the benefit he will receive for anesthesia services. Anesthesia indemnity will not be paid, however, where the anesthesia is administered by the operating surgeon and local anesthesia is not included as a benefit.

To date, ten groups have taken the new "Preferred Contract." Some are new groups enrolling for the first time, while others are groups transferring from the "Standard Contract" coverage.

Charles H. Coghlan, Executive Vice-President, stated that as the groups are informed of the additional benefits available under this new contract, he anticipates that a great number of groups will convert from the "Standard" to the "Preferred."

STEADY GROWTH

He also reported that the year 1952 showed a steady growth of Ohio Medical Indemnity. An additional 242,000 members were enrolled in 1952. Total enrollment reached 1,400,000 by the end of the year. With the increased enrollment, claim payments also increased. In 1952, over $7,000,000 was paid in indemnities to subscribers. Since the plan was started by the Ohio State Medical Association in 1946, $23,000,000 have been distributed to subscribers, represented by 415,000 claims. Currently, the Ohio Medical is enrolling approximately 20,000 new members per month and is paying $610,000 in claims per month.

Mr. Coghlan also reported that the national Blue Shield enrollment as of December 31, 1952, will exceed 25,000,000.

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Archives of Pathology;
Archives of Surgery;
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Archives of Ophthalmology;
Archives of Industrial Hygiene and Occupational Medicine.

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In Memoriam . . .

William C. Autenreith, M. D., Youngstown; University of Pennsylvania School of Medicine, 1910; aged 65; died December 31; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Autenreith had been a practicing physician in Youngstown since 1918. In addition to his professional work, he had been active in a number of community organizations, among them several Masonic orders, the Odd Fellows Lodge of which he was a past grand master, and the Lions Club. Surviving are his widow; two daughters, a son, two brothers and a sister.

Sanford E. Edwards, M. D., Marietta; Starling Medical College, Columbus, 1903; aged 77; died December 31; member of the Ohio State Medical Association; vice-president of the Washington County Medical Society in 1931 and its president in 1932 and 1938; delegate for several terms. Dr. Edwards had been a practicing physician in Washington County since 1908. Only recently he had been presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He had taken the medical board examination in West Virginia a year before he received his degree and practiced there for a time. Affiliations included memberships in the Church of Christ and the Masonic Lodge. Surviving are his widow, two sons, one daughter, a brother and four sisters.

Harry Flax, M. D., Cincinnati; University of Cincinnati College of Medicine, 1946; aged 30; died December 15. After serving two years with the Army Medical Corps, Dr. Flax had been associated for a time in practice with his brother, Dr. Nathan Flax, and only recently had been appointed to the radiology department of Speers Hospital, Dayton, Ky. Besides his brother, he is survived by his widow, a daughter, his mother and two sisters.

Harry M. Lackey, M. D., Wilberforce; Milwaukee Medical College, 1911; aged 69; died December 15. Dr. Lackey had been resident physician at Central State College, Wilberforce, and a practicing physician in Xenia for the past 31 years. He had previously practiced in Chicago. His widow survives.

Edward C. Ludwig, M. D., Columbus; Ohio State University College of Medicine, 1909; aged 70; died December 29; former member of the Ohio State Medical Association, last in 1944. A practicing physician in Columbus and staff member at White Cross Hospital for approximately 30 years, Dr. Ludwig had retired in 1944. He was a member of several Masonic orders. Surviving are his widow and three brothers.

Mathew C. Pirrung, M. D., Cincinnati; University of Cincinnati College of Medicine, 1921; aged 56; died January 3 at an Army hospital in Fort Sam Houston, Texas. Dr. Pirrung had been in practice in Cincinnati for approximately 20 years prior to World War II and had served a term as assistant Hamilton County Coroner and a period as police surgeon. He entered the Army with the outbreak of the war, and while in service in Europe suffered severe wounds from which he never fully recovered. Surviving are two sons, a daughter, and a brother, Dr. J. Edward Pirrung, of Cincinnati.

Thomas W. Roberds, M. D., Hillsboro (Belfast); Cleveland College of Physicians and Surgeons, 1889; aged 89; died December 18; member of the Ohio State Medical Association; member of the American Medical Association; president of the Highland County Medical Society in 1934. A native of Highland County, Dr. Roberds had practiced there for more than 60 years. Affiliations included memberships in several Masonic orders, the Knights of Pythias Lodge and the Presbyterian Church of which he was an elder. Surviving are a son, two daughters and three brothers.

James W. Rowe, M. D., Rochester, N. Y.; Medical College of Ohio, Cincinnati, 1895; aged 83; died December 28; former member of the Ohio State Medical Association, last in 1940. A native of Cincinnati, Dr. Rowe had served virtually all of his professional career there, where he was on the staff of the Department of Obstetrics and Gynecology, University of Cincinnati College of Medicine. He retired in 1941 and moved east in 1946. Surviving are his widow, two sons and a daughter.

Oliver P. Tatman, M. D., Chillicothe; Miami Medical College, Cincinnati, 1897; aged 78; died December 12; member of the Ohio State Medical Association; member of the American Medical Association; vice-president of the Ross County Academy of Medicine, 1919-1920 and its president, 1934-1935; also a delegate for several terms. A practicing physician in Chillicothe for 54 years, Dr. Tatman had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. Affiliations included memberships in the Elks Lodge and the Chillicothe Country Club. His widow survives.

Leonidas E. Wills, M. D., Columbus; Ohio Medical University, Columbus, 1897; aged 82; died December 11; member of the Ohio State Medical Association; member of the American Medical Association; secretary of the Pike County Medical Society for a number of terms, also delegate for a number of years; president of the Society,

1933-1935 and president-elect, 1948. Dr. Wills had practiced medicine in Pike County for 52 years with the exception of a brief stay in Colorado before he retired and moved to Columbus in 1949. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. Surviving are his widow, two sons, a daughter and a brother.

Edward Harlan Wilson, M. D., Columbus; Harvard University Medical School, 1920; aged 61; died December 14; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Orthopedic Surgery; member of the American Orthopedic Association, the Clinical Orthopedic Society, the American Academy of Orthopedic Surgeons and Fellow of the American College of Surgeons. Internationally recognized in his field, Dr. Wilson had been named resident director of the American Hospital in Oxford, England, in 1942. He also was a member of the Robert Jones Club of England and an honorary fellow of the Exeter College, Oxford. Dr. Wilson had been a practicing physician in Columbus since 1924, and was head of the Department of Orthopedic Surgery at Ohio State University College of Medicine and was supervisor of orthopedic surgery at Children's, University and Mt. Carmel Hospitals. He held memberships in several professional fraternities, several Masonic orders and the Rocky Fork Hunt and Country Club. Surviving are his widow; a son, Dr. Edward H. Wilson, Jr., with the Army Medical Corps in Germany; two daughters and a brother, Dr. Philip D. Wilson, New York.

Doctors Giving Liberally

An interesting article, "Doctors are Generous Givers," appeared simultaneously in recent issues of *Modern Hospital* and *Medical Economics*. The article, written by George Radcliffe, Senior Campaign Director, Ketchum, Inc., Pittsburgh, indicates that contrary to the opinion of many, figures on more than 1,000 hospital campaigns in 245 U. S. cities in the last 33 years reveal that the highest per capita contributions came from the doctors on their staffs. The recent survey of six major hospital campaigns shows that $928,661 was contributed by only 601 doctors. Analyzing these six appeals it was found that the doctors had contributed almost 8 per cent of the total. The average gift was $1,545.

List of Medical Films

The Committee on Medical Motion Pictures of the American Medical Association has announced publication of a new revised film list which includes 78 medical films not readily available from other sources. A copy may be obtained by writing the Committee at 535 N. Dearborn St., Chicago 10.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D. CINCINNATI)

HAMILTON

The Academy of Medicine of Cincinnati announced the following program features for February and March:

February 3—Dr. Edward Reynearson, professor of medicine, University of Minnesota, Rochester, "Clinical Disturbances of the Pituitary Gland."

February 17—Dr. Granville Bennett, professor of pathology, University of Illinois College of Medicine, Chicago, "Metabolic Bone Disease."

March 3—The Roger Morris Lecture—subject and speaker to be announced.

March 17—Dr. Jerome Conn, professor of medicine, University of Michigan Medical School, Ann Arbor, "The Diagnosis and Management of Spontaneous Hypoglycaemia."

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

MIAMI

The annual joint meeting of the Miami and Shelby County Medical Societies was held at the Piqua Country Club on January 8 with a luncheon. Speaker for the occasion was George H. Thompson, supervisor of claims, Ohio State Industrial Commission, Columbus, who spoke on the subject, "Doctors and the Ohio Workmen's Compensation Act."

Dr. George A. Woodhouse, Pleasant Hill, announced that he would relinquish the office of secretary of the Miami Society on June 1, 1953, upon completion of 25 years in that post. Dr. Dale Hudson, Piqua, is scheduled to succeed him.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

Dr. Wendell Green was installed as President of the Academy of Medicine of Toledo and Lucas County at the annual meeting held January 2, in the Commodore Perry Hotel.

Dr. F. F. Rawling, was named president-elect. Other officers are Dr. C. L. Felker, reelected treasurer; Dr. A. A. Applebaum, councilor; and Dr. Frederick P. Osgood (retiring president) member of the board of trustees.

Speaker for the occasion was Aubrey D. Gates, field director of the A. M. A.'s Council on Rural Health, who described the cooperative efforts being carried on by the A. M. A. with farm organizations and others interested in rural health.

A plaque was presented to the Academy by

Cook County Graduate School of Medicine

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, two weeks, starting Feb. 2, Feb. 16, March 2. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting March 2. Surgical Anatomy & Clinical Surgery, two weeks, starting March 16. Basic Principles in General Surgery, two weeks, starting March 30. Gallbladder Surgery, ten hours, starting April 20. Surgery of Colon & Rectum, one week, starting March 2. General Surgery, one week, starting Feb. 9. General Surgery, two weeks, starting April 20. Fractures & Traumatic Surgery, two weeks, starting March 2.

GYNECOLOGY—Intensive Course, two weeks, starting Feb. 16. Vaginal Approach to Pelvic Surgery, one week, starting March 2.

OBSTETRICS—Intensive Course, two weeks, starting March 2.

PEDIATRICS—Intensive Course, two weeks, starting April 6. Congenital Heart Diseases, two weeks, starting May 18.

MEDICINE—Intensive General Course, two weeks, starting May 4. Electrocardiography & Heart Disease, two weeks, starting March 16. Allergy, one month and six months, by appointment.

UROLOGY—Intensive Course, two weeks, starting April 13. Ten-Day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY—Intensive Course, two weeks, starting May 11.

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Toledo Public Health Association in recognition of the services of doctors to the community during the past 30 years. The plaque was presented by Donald A. Finkbeiner, secretary-director of the health association, and was received by Dr. Martin W. Diethelm, chairman of the board of trustees.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

"Cellular Immunology of Bacteremia" was the subject discussed by Dr. William Barry Wood, professor of medicine, Washington University, St. Louis, at the January 16 meeting of the Academy of Medicine of Cleveland. Respective sectional meetings of the Academy also were held during the month.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

Dr. William McDowell Hammon, professor and head of the Department of Epidemiology and Microbiology, University of Pittsburgh, spoke on the subject, "Recent Advances in the Immunization and Treatment of Polio," at the January 6 meeting of the Summit County Medical Society in Akron.

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

WASHINGTON

Three local doctors were honored for a half century or more of medical service at the December 10 meeting of the Washington County Medical Society in Marietta. They are:

Dr. S. E. Edwards, of Rathbone addition, Marietta, (since deceased) a native of Washington County and a practicing physician there virtually all of his professional life;

Dr. J. A. McCowan, Marietta, who has practiced in Noble County as well as in Washington County. He has served eight years as county coroner and recently was elected for another term.

Dr. Allison K. Walker has been living at Little Hocking for about the past two years, but practiced for 48 years at Buchtel near Athens.

The 50-Year Pin and Certificate of the Ohio State Medical Association was presented to each man by Dr. Robert S. Martin, Zanesville, Councilor of the Association's Eighth District.

Tenth District

(COUNCILOR: WM. F. MITCHELL, M. D., COLUMBUS)

FRANKLIN

At a meeting of the Council of the Columbus Academy of Medicine on December 18, the ballots in the annual Academy election were counted

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with the following results: Dr. Judson D. Wilson, president-elect; Dr. Philip Hardymon, secretary-treasurer; Drs. Harry E. LeFever and Tom F. Lewis, trustees; Drs. William F. Bradley and Robert E. S. Young, delegates; Drs. Joseph M. Gallen and Robert M. Inglis, alternates.

Dr. Robert C. Kirk, assumed office as president to succeed Dr. Warren G. Harding II.

KNOX

Two local physicians were honored by the Knox County Medical Society and the Ohio State Medical Association by being presented 50-Year Pins and Certificates of the State Association. Honors were bestowed at a dinner-dance at the Homestead Club, Mount Vernon, on December 15.

Those honored were Dr. Harry W. Miller, Mount Vernon, and Dr. C. L. Harmer, Danville. Dr. Miller has practiced both in this country and in the Orient, where he was a medical missionary for many years. Dr. Harmer has practiced his profession in Knox County since before World War I, and served for a number of years as county coroner.

Presentations of the 50-Year awards were made by Dr. William F. Mitchell, Columbus, Councilor of the Tenth District. The local Society also presented gifts to the doctors. Dr. John Woodland presided as retiring president of the Society.

ROSS

Dr. C. D. Leggett was honored at a dinner meeting of the Ross County Academy of Medicine and Auxiliary held at the Scioto Lodge on December 4, where he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. William F. Mitchell, Columbus, Councilor of the Association's Tenth District, made the presentation. Dr. F. W. Nusbaum, president of the Academy, was toastmaster.

Woman's Auxiliary . . .

By MRS. JAMES E. MULLEN, Chairman, Publicity Committee, 572 E. Front Street, Perrysburg

---

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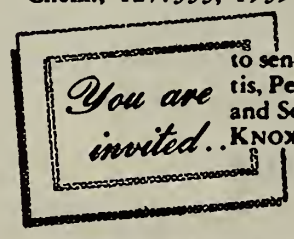
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1 Schoenheimer, R., Ratner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.



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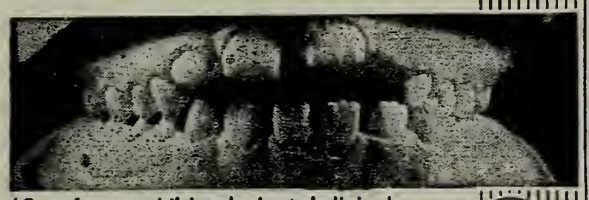
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April 20-23. All Resolutions should be in her hands **not later than April 16.**

COMMITTEE REPORTS

A report of this year's work is to be sent to respective State chairmen by the County chairmen of the following committees: Membership; Program; Public Relations; Legislation; Bulletin; *Today's Health*; and Publicity. These reports **should be ready by March 1.**

A. M. E. F. CONTRIBUTIONS

Additional contributions to the American Medical Education Foundation have been received from the following County auxiliaries: Sandusky, Summit, Marion, Montgomery, Licking, Delaware, Knox, Greene, Miami, Lucas, Champaign, and Franklin.

* * *

BUTLER

Butler County Auxiliary met on Dec. 9 at Fellowship Hall in the Middletown Presbyterian Church. Mrs. G. E. Marr presided at the business session, at which plans were made to present Christmas gifts to patients in the Hughes Memorial Hospital. Plans were announced for the "Esther Brosius Award," an essay contest, sponsored by the Auxiliary, and open to prospective nursing students now enrolled in high schools in Hamilton, Middletown and Butler County. Three prizes of $15, $10 and $5 are offered.

CHAMPAIGN

Members of the Champaign County Medical Society and the Woman's Auxiliary attended the annual Christmas dinner party Dec. 17 in Millner's Colonial room. Dr. E. R. Earle was presented a handsome billfold as a remembrance of his long years of practice in the county. Christmas music was presented by a quartet composed of Doctors David H. Moore, V. G. Wolfe, Francis Grogan and A. B. Ream.

DELAWARE

The Woman's Auxiliary to the Delaware County Medical Society met at the home of Mrs. James G. Parker on Dec. 9. Plans were discussed for the annual Heart Fund drive, and suggestions were made for the nurse recruitment program. Material was presented concerning the establishment of a nurses' loan fund, and a committee was appointed to study this subject.

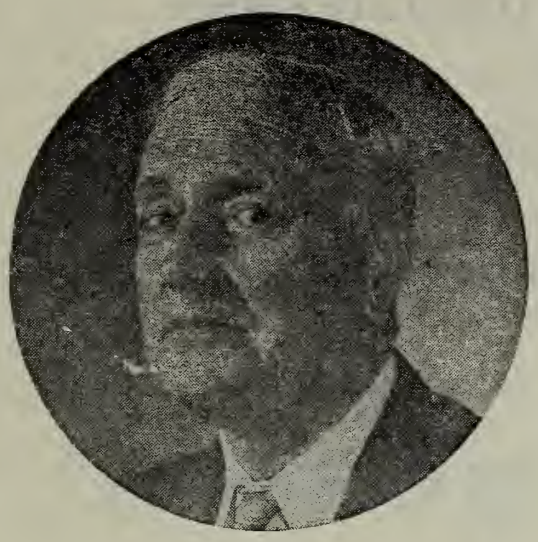
HURON

Mrs. Alex Kimmel was hostess to members of the Huron County Auxiliary on Dec. 12. Plans were made to offer another loan of $200.00 to assist a student nurse.

Two successful projects of the Auxiliary are collecting pictorial magazines for distribution to the aged, through the county welfare department; and the collection of costume jewelry for mental patients in Apple Creek sanitarium.

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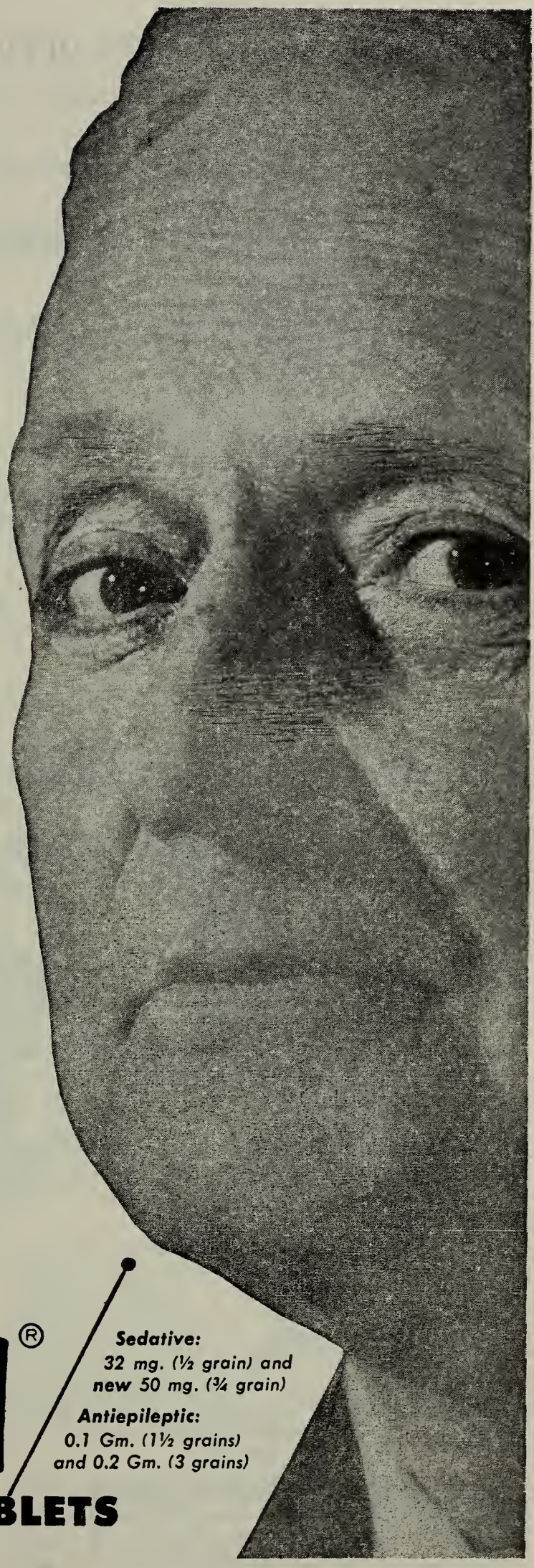
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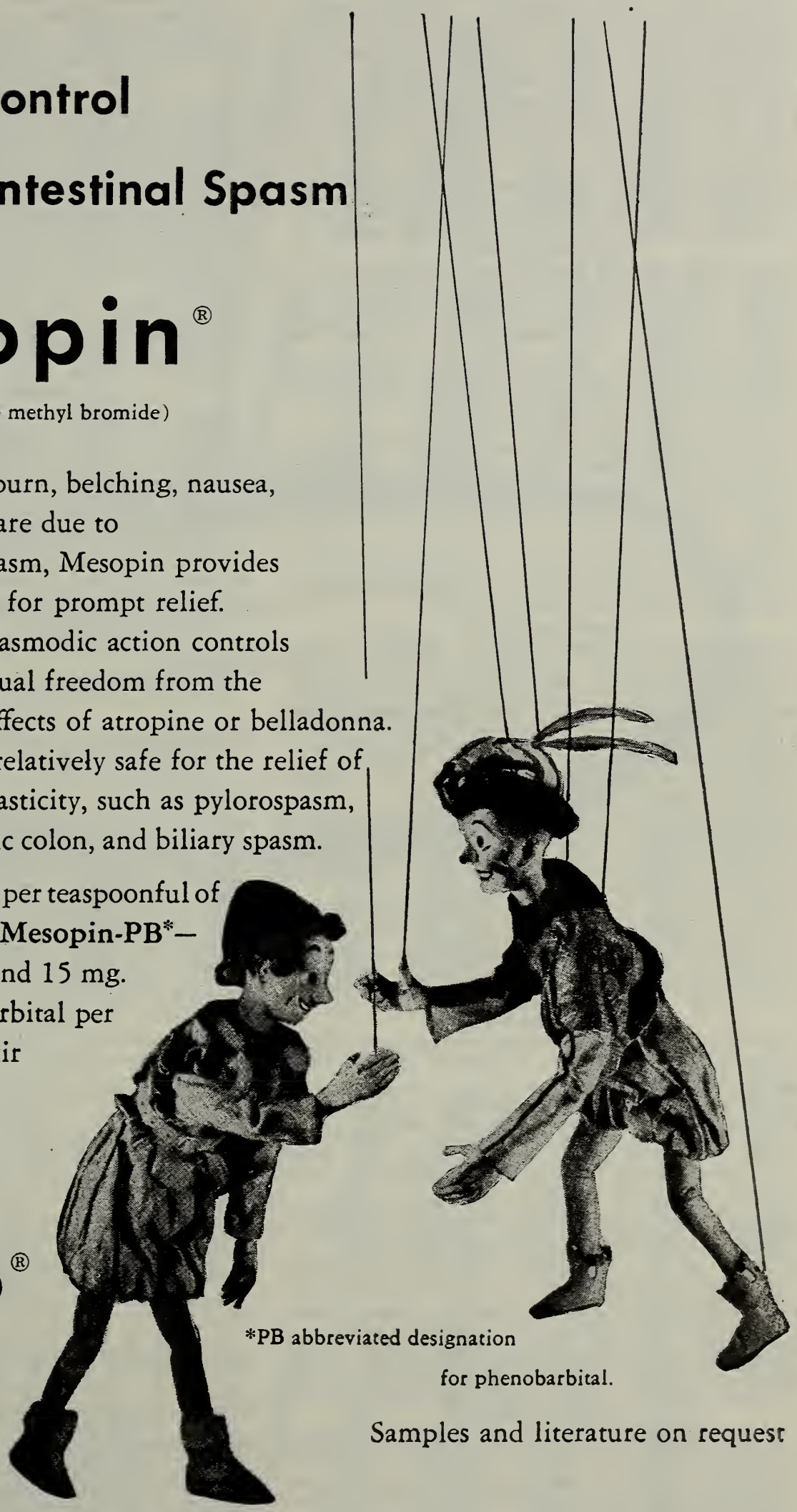
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Heredity in Uterine Cancer, by Douglas P. Murphy, M. D., ($2.50. Published for the Commonwealth Fund by *The Harvard University Press, Cambridge 38, Mass.)* On this unsolved problem, the author has collected two kinds of evidence, one based upon the occurrence of cancer in the same organ in more than one member of a family, and the other based upon the frequency of cancer in any part of the body among the relatives of a large series of individuals having cancer. These evidences support the conclusion that heredity factors do affect the frequency of cancer in the uterus; that the factors predisposing to cancer in the uterus do **not** predispose to cancer in other sites; that heredity factors other than those concerned with uterine cancer play a role in the etiology of cancer elsewhere in the body.

Health Observation of School Children, by George M. Wheatley, M. D., M. P. H., and Grace Taber Hallock; Illustrations by Barbara Pfeiffer. ($4.75. *McGraw-Hill Book Co., 330 W. 42nd Street, New York 18, N. Y.).* Designed as a guide to a better understanding of the health of children of school age, by the vice-president of The Metropolitan Life Insurance Company in charge of Health and Welfare. It will be a great help to teacher, parent, school and family physician.

Murder, Madness and The Law, by Louis H. Cohen, M. D., ($3.50. *The World Publishing Company, 2231 W. 110th St., Cleveland 2, Ohio).* In this work a psychiatrist looks at the insane murderer. Seventeen case histories are used as a basis for his discussion. The problem of why people kill is adequately brought out by this well-known psychiatrist with more than 20 years experience in the field.

Physician's Handbook, by Drs. Krupp, Sweet, Jawetz, and Armstrong, ($2.50. Seventh Edition. *Lange Medical Publications, University Medical Publishers, P. O. Box 1215, Los Altos, California).* Revised every two years, this time the book has been entirely rewritten. This edition, more than the previous ones, puts in the physician's pocket a brief but clear summary of procedures and factual data that should prove most acceptable and useful to him.

The Healing Touch, by Harley Williams, ($6.75. *C. C. Thomas, Springfield, Ill.).* In this volume, the author of **Doctors Differ** and **Men of Stress** takes such men as Sir William Knighton, Sir James Clark, and Sir William Jenner, all doctors of royality, on to Chadwick and South Smith and their pioneer work in Public Health, gives a penentrating analysis of Florence Nightingale; recounts the almost incredible Brown-Séquard and ends with the Mayo family. Running through highly dramatized sequence is the thread of personality. The fundamental aim of the author is to show that the Art and Science of healing is not only to relieve suffering but to make the patient whole, to help him realize his full mental and physical potentialities. You will enjoy every word of this book and you can do no greater service than to give it to the young student about to enter medicine.

National Income and Social Accounts—An Australian Study, by R. I. Downing, ($1.00. *Melbourne University Press; U.S.A., Cambridge University Press, 32 E. 57th St., New York 22, N. Y.),* presents the thesis that expenditure, production and income are identical. Income (and therefore employment and production) will settle at whatever level will make people willing to save an amount equal to the amount invested.

Christian Ethics, by Rev. Leo R. Ward, C. S. C., ($4.00. *B. Herder Book Co., 17 S. Broadway, St. Louis, Mo.).* The professor of philosophy at Notre Dame has written an excellent text on the subject. He has always been a staunch supporter of consumer cooperatives and the proper way to control monopolies in a republic. His chapter on the ethical aspects of socialization of medicine is somewhat colored in that direction. With perfect fairness he presents the views of your reviewer and his school of thought that we should move to eliminate DISease through improved diet and shelter. He insists and we cannot deny that the less fortunate minority of our society does not get adequate care for sickness of its members.

What the author does not bring out too well is that the economic status of this segment makes them a victim of first one sickness and then another. No sooner do you get them back on their feet than they succumb to another infection. Their diet, their housing, their hard physical labor and exposure to the elements without adequate clothing, contribute to the onset of degenerative diseases of one sort or another. Usually it begins early with the loss of teeth which no amount of dental care provided by the dental profession can restore. These poor people must eat too many starches for economic reasons and so with our devitalized starches "the motor" must burn out in a short time.

Medical and dental care are humanitarian gestures but your reviewer wishes that the good

priest could see how futile they are when compared with what free enterprise with cooperatives and other reasonable controls of monopolies and education in the maintenance of health would do for the situation. Voluntary insurance schemes against the cost of catastrophic illness have been developing ahead of the author while he has been collecting the data for his book.

The author accepts with Pius XI nationalization when there is no better way because the individual citizens and voluntary groups are not able to do for themselves and their fellows. He concludes with good reason that "as responsible citizens, it is our right and duty to continue to say that the problem is serious, is not being solved, and demands an adequate solution."

Your reviewer could quarrel with his indictment of Morris Fishbein and the old A. M. A. and his praise for the Elk City experiment. Nevertheless, it is felt that as a whole the author has done a judicial evaluation of the social problems and the ethical attitude that right thinking men should assume toward them. It is to be hoped that this great Christian gentleman will come to see that there is a difference between nationalization which can be accepted when we have to and socialization of the Anti-Christ which is creeping over the United States.

Connective Tissues, the Transactions of the Third Conference, Editor Charles Ragan, M. D., ($3.50. *Josiah Macy Jr. Foundation, New York, N. Y.).* The Foundation's Conferences attempt to get exchange of opinions and facts between disciplines by study of the problem of communication between them. In these days in which new knowledge is accumulating at a great rate, this exchange becomes a must. Here various authorities dealing with connective tissues from specific and specialized angles have been brought together in an attempt to effect a common mass of useful information for all. Consequently the structure, staining properties, the nature of reticulin and finally hypersensitivity and the hyperadrenal state are presented for mutual benefit through a frank discussion of the papers as they are presented. The part dealing with the role of connective tissue in the immune and allergic reaction will be of great interest to many physicians.

Biology and Language, by J. H. Woodger, ($8.00. *Cambridge University Press, 32 East 57th Street, New York 22, N. Y.),* is the 1949-50 Tarner Lectures and serve as an introduction to the methodology of the biological sciences including medicine. While it is a book for readers in all fields of biology it is not about biology as such but rather the statements which biologists make. It is the hope of the author that you and I will not only enjoy reading the book but that in addition we shall find it helpful in overhauling our linguistic habits, to solve many problems and to clarify many muddles that will remain in statements that we make about organism and how our theoretical statements come to be constructed on the basis of our observations.

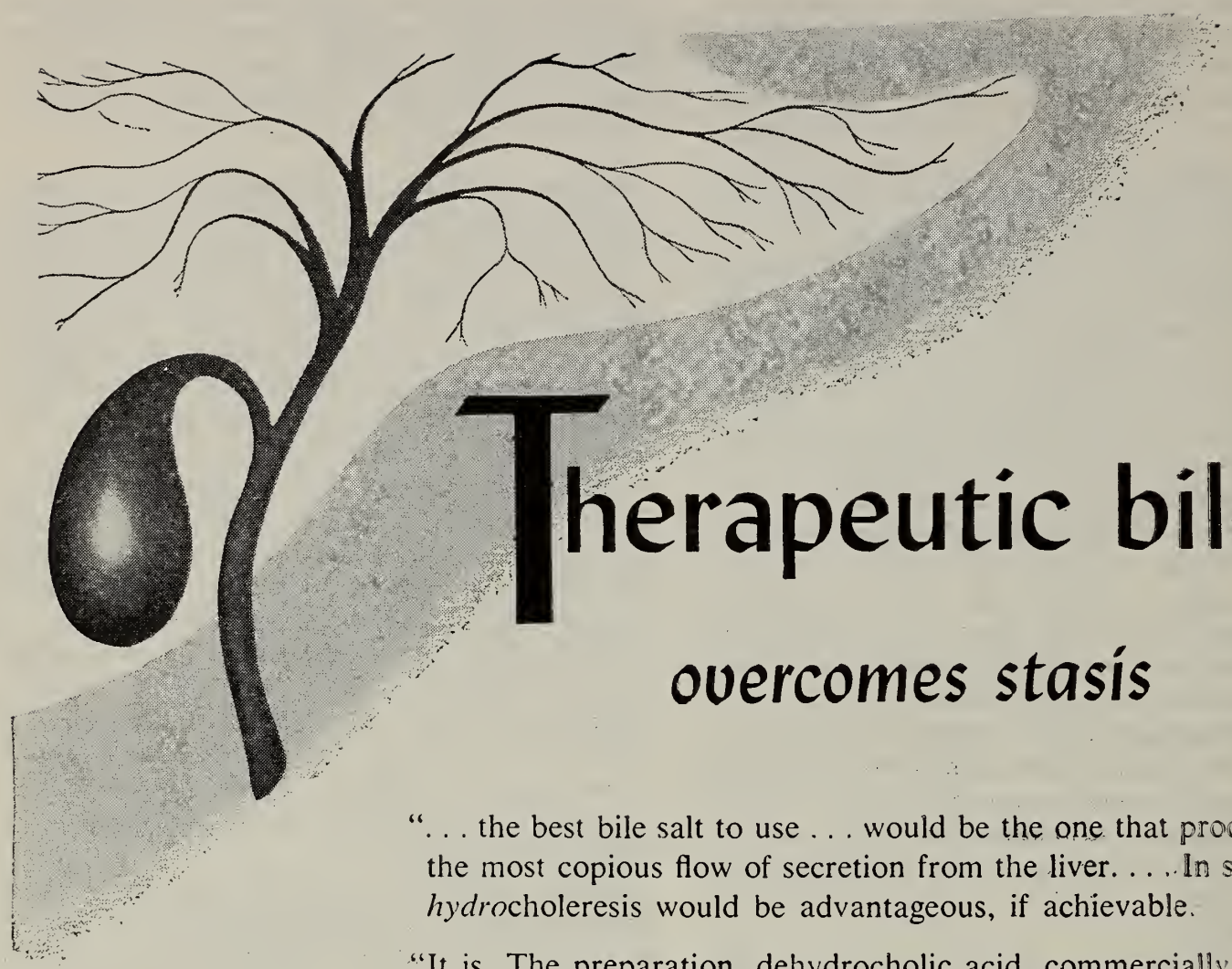
Diseases of Plants: An Introduction to Agricultural Phytopathology, by the late Neil E. Stevens and Russell B. Stevens. ($4.75. *The Chronica Botanica Co., Waltham, Mass.).* This text is designed to serve as a complement to the standard texts rather than to supplant them. It attempts to find a common ground in two different geographical areas—Tennessee and Illinois. It consists of 20 self contained lectures.

Life has always been an adventure for Man. Glaciation, floods, famine, pestilence, and DISease have made man active, versatile, inventive, and have kept his numbers down in keeping with the food supply. Wars have become, thanks to our mechanization, too inefficient. The per capita cost of the killing of the individual is rapidly pricing war out of the market of democracies. Pestilences are largely under control and DISease of man and his animals are so controlled that our population increases rapidly in spite of a declining birth rate.

Diseases and infestations of our plants upon which we must ultimately depend for our food is the greatest threat at present. It is for this reason that the student of disease must become familiar at least with the principles involved in the **Diseases of Plants.** Here in 200 well written pages one can do just that, easily and accurately.

Clinical and Roentgenologic Evaluation of the Pelvis in Obstetrics, by Howard C. Moloy, M. D., ($2.50. *W. B. Saunders Co., Philadelphia, Pa.),* is to be welcomed as the first of a series of small monographs intended to bring us the practical research in special fields of medicine. Your reviewer has always tried to boost this type of publication realizing full well that the Book Trade has not found a way to make a reasonable profit therefrom. Grasping the facts set forth will help the student of to-day to begin his knowledge of pelvic disproportion at a stage reached by his predecessors only after years of painful experience.

The Adolescent Period, A Pictorial Atlas, by Frank B. Shuttleworth, Monograph of the Society for Research in Child Development, Inc., Vol. XIV, Serial No. 50. No. 2, 1949. *(Child Development Publications, Fayerweather Hall, East, Northwestern University, Evanston, Ill.),* is the second number in the Shuttleworth series illustrating the processes of growth maturation, and differences in body build among normal adolescents. It is essentially 400 photographs of nude children arranged in 52 figures, and is intended primarily as a work of reference for students of child development.



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*Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

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JONATHAN FORMAN, M. D., *Editor*

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An Unusual Case of Malignant Thymoma

MARVIN S. FREEMAN, M. D.

THERE is probably no organ in the human body about which physicians have as little knowledge as the thymus. The following quotation is from an editorial,[1] which appeared in *The Lancet*: "The thymus gland . . . has remained an enigma. Endocrinologists, physiologists and pathologists have drawn away from it baffled. Not even the anatomists or histologists have spoken of it with their customary precision and we are still uncertain whether it has any real existence in the normal adult, and whether the main cells of its medulla are to be regarded as epithelial or endothelial."

In recent years, however, there has been considerable interest in this organ, and although it must be admitted that there is very little definite scientific knowledge about the thymus, there has accumulated a considerable body of evidence suggesting a relationship between abnormalities of this gland and the disease myasthenia gravis. This association was first noted by Weigert[2] in 1901. Since that time, numerous writers have contributed considerable evidence to support the thesis that abnormalities of the thymus manifested by enlargement or tumors of this organ occur in a much higher percentage of cases of myasthenia gravis than can be accounted for by coincidence.

Further evidence of the association of myasthenia gravis and the thymus is that in selected cases deep roentgen therapy applied over the thymus has produced a remission of symptoms. In the more recent literature, there have been reports of myasthenia gravis in which this treatment or surgical removal has produced improvement, and in some instances, complete remission of symptoms has occurred.

Submitted October 8, 1952.

The Author

● Dr. Freeman, Cleveland, is a member of the active staff at St. Luke's and Lutheran Hospitals; associate staff, Fairview and Lakewood Hospitals, Cleveland; and on consulting staff at Berea Community Hospital. Demonstrator, department of anatomy, Western Reserve University.

The term thymoma, introduced by Grandhomme,[3] denotes a slowly growing tumor of the thymus which has arisen from both the epithelial (reticulum) and thymocytic elements of the thymic parenchyma. Typical Hassall's corpuscles are absent in most thymomas. Very common are such features as a dense fibrotic capsule, distinct fibrous trabeculae, and palisading of epithelial cells about cystic spaces, blood vessels and fibrous trabeculae. Frequently areas of necrosis, cyst formation and calcification are seen.

Ewing[4] compares the term thymoma to that of the term lymphoma. Those tumors which metastasize cannot be distinguished on an histologic basis from those which do not. The tumors are composed of two cell types: one is identical with small lymphocytes seen in lymph nodes; the other is oval, three to four times as large as a lymphocyte, containing an acidophilic cytoplasm and a nucleus which stains lightly with hematoxylin.

The thymus gland takes its origin from the third visceral cleft of each side and consists of two lobes, one of which is formed from each lateral diverticulum. The upper part is at first tubular but gradually becomes a solid structure.

The thymus is believed by many investigators to be originally epithelial in structure reaching its maximum growth and finally becoming mainly lymphoid in type by the end of the second year. The gland remains essentially stationary in growth until puberty after which it rapidly atrophies.

The two lobes of the thymus lie in the midline in close contact with each other and extend from the lower border of the thyroid gland to the fourth costal cartilage. In the neck the thymus rests on the trachea and is covered by the sternohyoid and sternothyroid muscles. In the thorax, the gland lies directly beneath the sternum. It rests below upon the pericardium, being separated from the aortic arch and the large vessels by a thin layer of fascia.

Tumors of the thymus are not common. Symmers,[5] after reviewing 17,000 autopsies at Bellevue, found 25 thymic tumors or enlargements. Eaton et al.,[6] indicate an occurrence of thymic tumors in 15 per cent of patients with myasthenia gravis. In 32 patients with myasthenia gravis, Clagett and Eaton[7] found 15 thymic tumors at operation with a preponderance in males. They noted an age range of 25 to 57 years with an average of 42.3 years. It is interesting to note that Seybold et al.,[8] reported that 11 out of 45 tumors in their series occurred in patients who had no evidence of having myasthenia gravis at the time of operation and who subsequently have had no symptoms of this disease.

CASE REPORT

The patient, a three year old white male was seen for the first time at 2:00 a. m. on February 3, 1950, in the emergency room of a local hospital. History revealed that the chief problem was one of acute respiratory distress and intense cyanosis.

Past History: This child had been a normal full term infant. His subsequent development was normal until he first began to sit, (at approximately 6 to 8 months of age), when it was noted that he would have sudden episodes during which his body would become tense followed by marked cyanosis and periods of unconsciousness which lasted for as long as one to two minutes. These episodes were usually followed by untroubled sleep. Neither urinary nor fecal incontinence were ever noted. These attacks seemed to become more severe until the age of 1½ years when the patient began to walk at which time an unusually severe episode occurred. Medical opinion at this time offered a diagnosis of "temper tantrums." He continued to have intermittent recurrences, which seemed to be of milder intensity as long as his activities were restricted. The last attack had occurred about one year before this admission to the hospital.

Two months before admission the patient became ill with stridorous respiration and cough. This illness was diagnosed as a "strep throat" and treated with an antibiotic.

Present Illness: For two weeks before admission, the child had had "whistling" breathing and occasional paroxysms of cough associated with poor appetite. He played in a normal fashion. Shortly before admission, his respirations became more stridorous and his father noted for the first time a bulging of the left side of his chest. Cyanosis intervened and gradually became more profound. In desperation, the child was finally brought into the emergency room.

Examination revealed a well developed and well nourished three year old white male in obvious acute severe respiratory distress and not responding to normal stimuli. The temperature was 96.6°F., pulse 140, and the respirations were 32 per minute. The skin was cold and dry and marked cyanosis including the lips and nail beds was present. The eyelids were widely open and although the pupils were dilated, round and equal, they reacted normally to light. The teeth were tightly clenched and tensing and jerking of the lips was noted with each inspiration. No nuchal rigidity was present.

The thorax showed marked retraction of the lower costal borders with each inspiration. Little if any retraction of the intercostal, suprasternal and supraclavicular spaces was present. There was a slight bulging in the left precordium. Coarse, inspiratory rales were heard in both lung fields with a marked expiratory phase. The breath sounds were diminished over the left chest with pronounced dullness to percussion. Examination of the abdomen, genitalia, tendon reflexes and extremities revealed no abnormalities.

Bronchoscopy: The seriousness of the patient's condition interdicted prolonged consideration of a differential diagnosis and bronchoscopy without anesthesia was performed with dispatch while oxygen was administered through the side channel of the bronchoscope. The orifice of the left main stem bronchus was seen to be markedly compressed to the point of almost total occlusion. No other abnormalities were noted. The possibilities of lung tumor or massive pleural effusion were considered, and the patient was returned to the ward for supportive therapy, further investigation to be carried out the following day. He expired at 7:30 a. m., approximately five hours after admission.

Postmortem examination revealed a large tumor mass occupying the anterior mediastinum and approximately two-thirds of the left pleural cavity. The comparative size of this tumor is shown in figure 1.

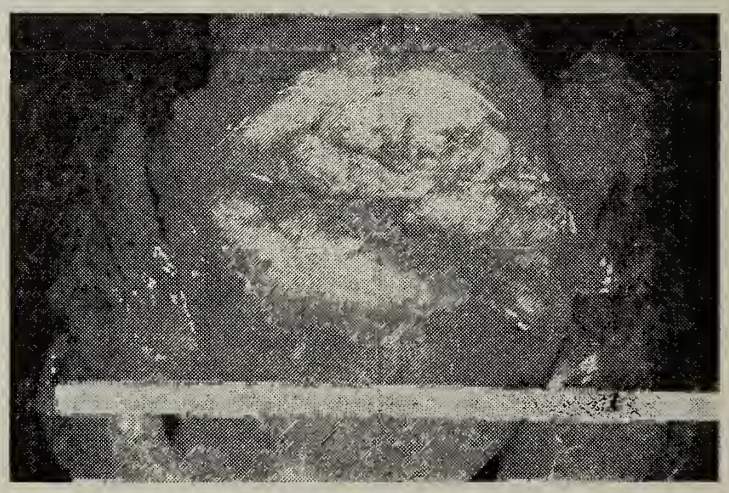


FIG. 1

The entire lower lobe of the left lung and a major portion of the upper lobe were compressed by the tumor. Marked displacement of the heart and compression of the main stem bronchus were present.

The tumor occupied the customary position of

the thymus and measured 16 by 11 by 7 cm. The nodularity of its cut surface is well shown in figure 1. No invasion of the adjacent structures was noted. Enlarged lymph nodes about the right main stem bronchus and a nodule within the diaphragm contained tissue similar to that of the tumor.

Sections of the thymic tumor showed obliteration of the usual architecture. (Fig. 2)

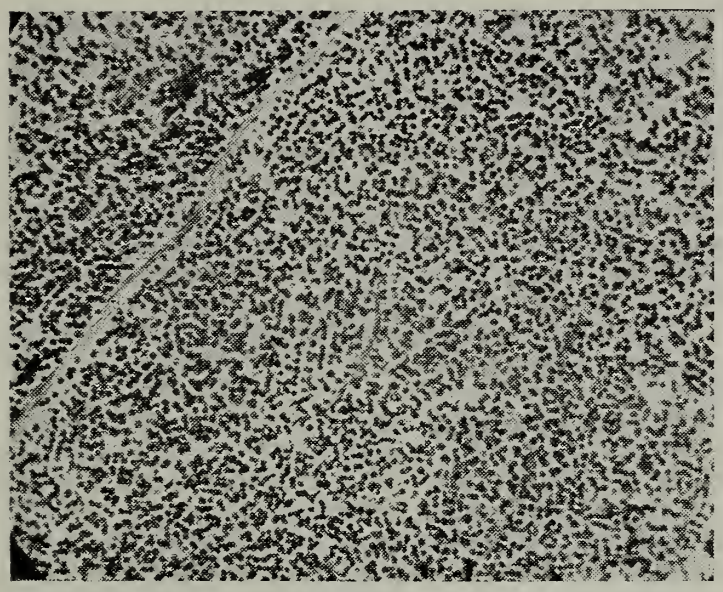


FIG. 2

It was composed of small round cells resembling lymphocytes. The nuclei showed little pleomorphism, although some were enlarged and had increased staining reaction of the chromatin material. Mitotic figures were sparse. The interstitial tissue was very small in amount and consisted of fine pink fibers. Much of the tumor was surrounded by a capsule which was invaded with small round cells. No Hassall's corpuscles were found within the tumor. The peribronchial lymph nodes and the nodule within the diaphragm presented a similar microscopic picture.

COMMENT

An unusual case of malignant thymoma with metastases to the regional lymph nodes and diaphragm is presented. This case appears to be that of one of the youngest patients reported. With such a slow-growing tumor, cardiopulmonary compensation was apparently adequate for a prolonged period. It is interesting at least to speculate as to possible outcome had routine radiography been employed.

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A Choriocarcinomatosis in a Young Male—Case Study

PHILIP C. STIFF, M. D.

CHORIO-EPITHELIOMA occurs as 0.016 per cent of all tumors in the male[1] and occurs in young males between the ages of 20 and 40 years in 75 per cent of cases. Ninety-eight per cent have been terminated fatally.[2]

The usual findings in over 400 reported cases are related to a primary testicular lesion; but extra genital chorio-epitheliomas do occur with the history of a mediastinal teratoma.[3]

The tumor may be a hormone-producing tumor. The hormone in choriocarcinomas of patients with testicular tumor is identical with the hormone produced by the chorionic structure and is found in the urine of pregnant females.[4] This finding of prolan A in the urine of young males is enough to diagnose (pre mortem) a choriocarcinoma.

The use of special virus preparations today may become a new method of ameliorating carcinomatous processes. Special viruses were used on this patient at Johns Hopkins Hospital when the prognosis was poor and temporary improvement resulted. A report of this patient's case follows.

The Author

● Dr. Stiff, Toledo, Ohio, is an attending member of the staff at St. Vincent's, Toledo, Mercy, and Maumee Valley Hospitals.

CASE REPORT

The patient, a white male, age 27, was seen on December 5, 1949 for "hurting in his stomach," pain over his kidneys and bilateral flank pain on palpation. Chest fluoroscopy was negative, as was fluoroscopy of the esophagus and stomach. Corrected sedimentation rate, 40 (Wintrobe). Hematocrit 50. Hemoglobin 17 gr., or 100 per cent. Red blood cells, 4,440,000. White blood cells, 8,150. No adequate explanation for such a high sedimentation rate was found. Urinalysis was negative. His medication was phenobarbital and salicylates.

Patient was hospitalized on March 22, 1950 for intermittent, severe abdominal pains in left upper quadrant. The pain occurred in the middle of the night and was associated with nausea and vomiting. There was no abdominal distention, tachycardia, prostration, fever or chills. The attacks became more frequent and were relieved by bending over, pressing a pillow against his abdomen, or by salicylates.

Past history revealed only trench foot while in service in 1946 and pneumonitis 6 months prior to onset of present illness. Family history was non contributory. Habits: Alcohol—social. Sleep —8 hours. Cigarettes—one-fourth pack daily.

General Inspection: White male, aged 27 years, in pain and acutely ill. Head: Eyes—fundi negative. Pupils equal. Glands negative. Thyroid non-palpable. Mucous membranes dry. Thorax: Heart—negative. Lungs—clear. Fluoroscopy—chest essentially negative. Blood pressure 100/80.

Abdomen: A questionable mass in left upper quadrant which did not move on respiration. Area was painful to touch with muscle guard present and mass seemed to be detached from spleen. Liver—didn't seem enlarged. No pulsation was felt in abdomen or over area of tenderness. Genitalia: Prostate normal; no tenderness. Testicles normal to palpation. Extremities: Negative. Neurologic—negative.

Impression: (1) Left pyelonephritis with renal calculi?; (2) Gastric ulcer?; (3) Congenital kidney.

Course in Hospital: Patient was seen by surgical consultant who noted history and found "L. U. Q. muscle guard." His impression was either a left nephrolithiasis; internal hernia or amebic colitis. An intravenous pyelogram was made and revealed a rotated left kidney. Retrograde pyelography revealed a malrotation of left kidney; otherwise the urinary tract was within normal limits. Urine specimen—right kidney 50 to 60 red blood cells. Left kidney 1 to 2 white blood cells; 1 red blood cell.

A complete gastrointestinal roentgen ray series was normal. Stool examinations revealed no ova or parasites; occult blood positive; no pathogens found on culture. Sigmoidoscopy was normal. Nonprotein nitrogen—35 mg. per 100 ml. Urinalysis reaction 6.0. Specific gravity, 1.023. Albumin negative. Sugar negative.

March 21, 1950: Red blood cell count was 5,020,000. White blood cells, 8,900. Hemoglobin—96 per cent, or 14 gms. Segmented neutrophils, 69. Stab forms, 2. Lymphocytes, 25. Monocytes, 3. Corrected sedimentation rate, 33 mm. Hematocrit, 51 vol. per cent.

March 27, 1950: Red blood cells, 4,250,000. White blood cells, 5,000. Corrected sedimentation rate, 23 mm. Hematocrit, 34 vol. per cent. Hemoglobin, 13.5 gm., or 95 per cent. Segmented neutrophils, 65. Lymphocytes, 30. Monocytes, 2.

The patient was discharged on the 7th day with no symptoms and the abdominal findings had reverted to normal. Temperature, pulse and respiration were normal.

On May 30, 1950 patient awoke finding glandular swelling in the left supraclavicular area which "came up over night." Glandular swelling in groin and axilla was also found. In these areas only discrete single glands were found. He had had a recent pharyngitis so chloromycetin® in large doses was instituted with heterophile being accomplished on second and seventh days of illness which were negative.

Patient was admitted to St. Vincent's Hospital, Toledo, Ohio, on June 10, 1950 at 3:30 p.m. with: (1.) Swelling in left neck, 5 cm. by 5 cm.; (2.) Epigastric distress—6 months; (3.) Back ache—6 months.

Present Illness: Onset of present difficulties began about 6 months ago with back pain which is in both flank regions, most severe on the left. Has also had epigastric burning which comes on one hour or so after eating, relieved by "white medicine."

Four days before admission he noticed a mass

Submitted July 15, 1952.

develop in the left neck which he had not seen before. This mass has not been tender and has regressed some in size. Three days afterward he became hoarse and the hoarseness has subsided some, but is still present. He had not noticed a lymphadenopathy anywhere else.

No history of weight loss. Bowels have been normal until he began taking some "white medicine" and they have been tarry and loose since. No cardiac symptoms.

Physical Examination: Blood pressure 120/70. A 28 year old, well developed, well nourished, white male. Head and Ears, Nose and Throat—voice somewhat hoarse. Chest—clear. Heart—no murmur. Neck—there is an obvious mass in the left neck, extends medially to the tendon of the sternomastoid, laterally to the mid-clavicular line, inferiorly below the clavicle and superiorly to a line extending laterally from the lower part of the mandible about 8 cm. It is not tender but is hard and not movable. There are a few small, movable nodes in the neck. Abdomen: Not tender. Liver, Kidney and Spleen are not palpable.

Lymph Nodes: Inguinal and axillary—bilateral, multiple, fairly firm, non-tender, palpable nodes. No epitrochlear nodes felt. It was thought patient had metastatic lesion so a biopsy was made.

Biopsy Report: Gross description of a biopsy of cervical mass: Four very irregular firm pieces of tissue average size from 7 mm. in diameter to 1.5 by .8 by .6 cm. Microscopic Examination: The tissue is largely mecrotic, but in some areas contains very large irregular cells which are rather well recognizable. The cells appear to be in part surrounded by blood and fibrin and in part invade into fibrous tissue. Frequently the cells form large syncytium with multiple nuclei. Often the cytoplasm is vaculated or foamy in appearance, at other times it has uniform glandular appearance. The nuclei are everywhere very large, hyperchromatic with very large nucleoli.

Diagnosis: Anaplastic malignant tumor. In some areas the tumor has an appearance of a chorio-epithelioma.

June 12, 1950: Urinalysis—color light amber. Character, slightly cloudy. Reaction, A. Specific gravity, 1.027. Albumin, very faint trace. Red blood cells, 0 to 2. Sugar, 0. Epithelial cells, few.

June 19, 1950: Red blood cells, 3,670,000. White blood cells, 5,400. Hemoglobin, 73.7 per cent, or 11.5 gm. Stab forms, 4. Segmented neutrophils, 65. Lymphocytes, 23. Monocytes, 7. Basophil, 1. Blood sedimentation June 19, 1950: Sedimentation time 60 minutes. Sedimentation index 32 mm. Hematocrit, 45.

June 24, 1950: Urine for prolan A was positive on two occasions.

X-Rays: Examination of the chest shows no abnormality of the thoracic cage, diaphragm, heart or aorta. Calcifications are present in both hilus shadows. There is no evidence of significant parenchymal lesion. No evidence of mediastinal widening is seen. Film of the abdomen fails to show the kidney shadows to good advantage. However, no definite abnormality is seen on either side. The liver shadow does not appear to be enlarged and the spleen appears to be within normal limits. No evidence of abnormal soft tissue masses.

Patient developed a midline epigastric mass which was not movable. Pain after eating developed and was somewhat relieved by vomiting but narcotics were needed.

Treatment: X-Ray therapy was given and patient did not show any improvement. His abdominal pains became worse and he was transferred to another hospital where he was given a potent virus preparation of dengue fever. He developed dengue fever and for a period, at least, his tumor was improved. The subcutaneous mass in the epigastrium almost disappeared and an intra-abdominal mass regressed partially which by palpation measured roughly 11 cm. across and 2 cm. above the umbilicus. Later, however, the masses returned and the patient's pain returned. He was then given a virus of infectious hepatitis. While the patient developed jaundice before death, it was not felt that he had infectious hepatitis but more likely obstructive jaundice.

Autopsy in substance revealed a peculiar embryonal carcinoma of the left testis. Choriocarcinomatous and papillary adenocarcinomatous tumor metastases to lymph nodes, liver, pancreas, adrenals, duodenum and lungs. Marked interstitial cell hyperplasia of the left testis. Slight atrophy of right testis. Tumor compression of bile and pancreatic ducts. Jaundice. Early biliary cirrhosis. Moderate interstitial fibrosis of the pancreas. Thrombosis of hepatic branches of portal vein and inferior vena cava. Encapsulated caseous nodules in spleen. Ascites—900 cc.

SUMMARY

A case report of a fulminating metastatic chorio-epithelioma in a young male with testicular origin proved by autopsy and urinary follicle stimulating hormone test. The use of dengue fever virus and infectious hepatitis virus resulted in moderate subjective and objective improvement.

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Pulmonary Emphysema

The loss of elasticity of the lung interferes also with emptying of the lung on the passive expiratory phase, with the result that there is a smaller differential between the interpleural pressure and the atmospheric pressure. The normal patient can develop the negative intrapleural pressure and therefore has a greater differential between atmospheric pressure and intrapleural pressure.

The patient with pulmonary emphysema does not have that degree of differential between atmospheric pressure and intrapleural pressure, with the result that his lungs are inadequately filled. In addition, there is inadequate emptying. The diaphragm stays depressed, the chest does not collapse, and the lungs remain relatively inflated with consequent inadequate tidal exchange, as well as diminished minute volume exchange. —State University of Iowa College of Medicine Clinical Pathologic Conference, *J. Iowa State M. S.*, 42:577, December, 1952.

Post-Traumatic Diaphragmatic Hernia

JULIEN M. GOODMAN, M.D., and GEORGE F. JONES, M.D.

ACQUIRED diaphragmatic hernia should be considered in every upper gastrointestinal complaint where a history of a previous crushing injury to the chest or upper abdomen is obtained. It may manifest itself only on thorough radiologic investigation. Subjective symptoms are often misleading, since the patient may localize his discomfort to the epigastric or substernal regions and state that his distress occurs after meals with relief obtained by vomiting.[3]

Diaphragmatic hernias of the congenital or acquired types have been studied in detail,[5] but Carter, Guiseffi, and Felson, directed attention to the increasing number of traumatic diaphragmatic hernias.[2] These were classified into those caused by: (1) stab wounds; (2) gunshot wounds; (3) indirect violence (falls, crushing injuries and steering wheel accidents); and (4) operative incision of the diaphragm. The third type, occurring most frequently on the left, often goes unrecognized.

Symptoms may not present themselves until after a considerable period of time following the injury has elapsed, and then are of a gastrointestinal nature. Also, it is significant, that traumatic hernias occur through the dome or lateral portions of the diaphragm.[4] Therefore, the location of a diaphragmatic hernia can suggest its mode of origin.

SYMPTOMATOLOGY

Heartburn, dyspepsia, flatulence, and regurgitation may be produced by esophagitis.[1] So common a group of complaints may be treated symptomatically with anti-acids, aluminum hydroxide gels and anti-spasmodics. When no relief of symptoms is obtained by this regimen, roentgenologic study directed at disclosing a peptic ulcer, cholecystitis, or gastric neoplasm may be undertaken, but when unrevealing, the symptoms may be construed as neurogenic. A valuable clue to the etiology of this syndome may be disclosed by a history of an old crushing injury to the chest or upper abdomen, which will direct attention to the status of the diaphragm. Such is often obtained only by diligent interrogation of the patient regarding particularly automotive injury.

ANATOMY

Achalasia or cardiospasm is simulated in a diaphragmatic hernia, by the creation of an occlusion at the esophagogastric junction by the increased angulation resulting from the counterclockwise rotation of the fundus. At the esophagogastric junction, the anteroleft lateral deflection of the alimentary tract is fixed by the attachment of the right posterior portion of the esophagus with fibers of the right crus, which is joined to the lumbar spine. The left crus, about which the curve is made, contracting with the right crus increases the angulation which prevents regurgitation of stomach contents.

Thus, if the fundus rises from its normal position, it produces the same effect, by increasing the angulation and occluding the lumen of the esophagus, thereby preventing not only regurgitation of stomach material, but also the passage into the stomach of the esophageal contents (Fig. 1). The former is a transient state, while the latter is constant, only remitting when the fundus returns to its normal position. When adhesions make the high position of the fundus permanent, then the symptoms of esophageal obstruction appear.

In the erect position, an occlusion may open

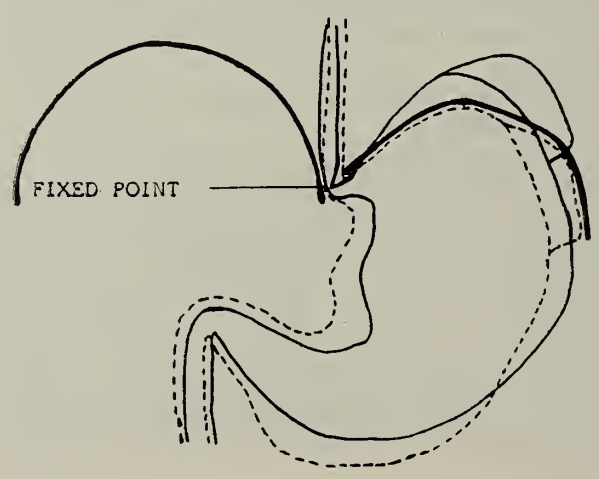
Submitted November 12, 1952.

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FIG. I



Diagramatic Illustration of esophageal constriction caused by rotation of stomach.

slightly, due to the downward pull on the stomach by the greater omentum, and the pull of the duodenal suspensory muscle (Ligament of Treitz), which orginates by slips on either side of the esophageal orifice. With weight loss and loss of fat in the greater omentum this ceases to effect the above result.

DIAGNOSIS

With prolonged obstruction of this nature cachexia due to slow starvation is added to the dysphagia and anorexia already present. However, in the less characteristic cases, even radiologic study with opaque media may be of little diagnostic help. Here a wasted physical status, with a story of constant fullness and lack of appetite together with frequent recurrent vomiting episodes may suggest the proper diagnosis. X-ray

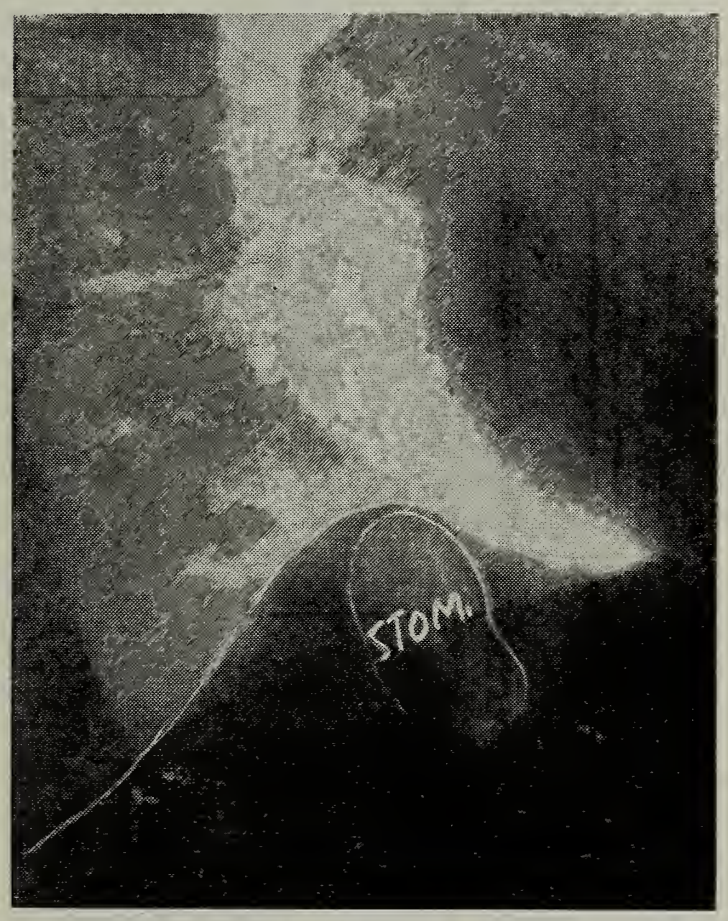


Fig. 2. Lateral film showing abnormal hump in posterior portion of left hemidiaphragm.

studies may demonstrate nothing more than an abnormally thin left hemidiaphragm with unusual contour.

Stress should be laid upon fluoroscopic and roentgenographic investigation in all planes. Parenthetically we would add that patients observed soon after a traumatic insult to the diaphragm are often confusing clinically and roentgenologically and the use of opaque substances via esophagus and rectum is required to adequately interpret elevated or otherwise obscured diaphragm outlines.

TREATMENT

The treatment is surgical reposition of the displaced organs and repair of the diaphragm through a left thoracotomy. The rotation of the stomach may carry the spleen through the defect in the diaphragm and thus further encroach upon the diminished esophagogastric lumen. With restoration of proper anatomical position, all symptoms disappear, as early as the first postoperative day. We have had the opportunity to treat such a case which we wish to present here.

CASE REPORT

A white, retired, 60 year old coal miner was admitted on May 10, 1951, to Mt. St. Mary Hospital, Nelsonville, Ohio, complaining of pain in the left chest, which radiated down the left arm, inability to eat solid food, and nausea accompanied by vomiting if he moved about within two hours after eating.

Past History: The patient had suffered a crushing injury in a mine fall 10 years before which involved his left chest and upper abdomen. He recovered slowly from this, and had no residual complaints. Seven years before admission he began to notice that he could not eat large meals without regurgitating, and that if he moved about immediately after eating, nausea followed by emesis of all the food eaten would follow. He learned by experimentation, that eating small quantities of soft or liquid food and sitting bolt upright for two or three hours following this, would prevent the symptoms; however, during the last year this practice has become ineffective with a gradually increasing tendency to vomit everything ingested. He has lost 45 pounds in weight in the last year. He also has noticed during the last six months occasional pain in the left shoulder and chest, which radiated down the lateral aspect of his left arm on vomiting or coughing.

Physical examination showed that the patient's temperature was 99° F., pulse 82, respiration 24, and blood pressure 148/92. Significant findings were a loss of tissue turgor and loose pendulous skin over the entire body. The dental hygiene was poor.

Laboratory findings: Red blood cells 4,020,000; white blood cells 8,650; 72 per cent neutrophils, 26 per cent lymphocytes, and 2 per cent eosinophils. Hemoglobin 13.3 grams, or 87 per cent. Urinalysis was entirely negative. Electrocardiography indicated slight myocardial damage.

Radiologic Findings: Both diaphragms moved synchronously and had normal excursions. Gastrointestinal and barium enema series demonstrated no intrinsic abnormalities of the entire alimentary tract. Progress of the barium column at 6 hours was normal. Anteroposterior, lateral and oblique studies of the diaphragm proved it to be thinned on the left side with an abnormal local hump in the posterior portion associated with abnormal proximity of the barium-filled gastric fundus to the lung above. The impression that this might be related to his thoracic injury was suggested, with a dehiscence of the diaphragm (Fig. 2).

The patient was presented with findings and readily accepted surgical intervention, since he felt that he was rapidly failing physically.

Operation: On May 23, 1951, he was taken to the operating room where under an endotracheally administered anesthetic, a left exploratory thoracotomy was carried out through a posterolateral approach in the sixth left interspace. The left lung was allowed to collapse disclosing the hump in the diaphragm noticed by x-ray. Here the diaphragm was thin and flabby, and fixed to a solid viscus beneath, which was carefully opened revealing the upper splenic pole and fundus of

the stomach attached to the under surface by dense adhesions. The stomach and spleen were replaced in the abdomen and the diaphragmatic peritoneum closed with fine silk sutures. The aponeurosis of the central tendon was thinned and lax, so that an imbrication of the anterior flap over the posterior flap was done with silk. The chest was then closed without drainage, using intramedullary bone pegs as suggested by Klassen,[6] after inflating the left lung, and he was returned to his room in good condition.

The patient took liquids the day of surgery and rapidly advanced to a regular diet on the second postoperative day. Thoracentesis was done on the third and sixth postoperative days, with complete reexpansion of the left lung and restoration of the normal contour of the left diaphragm on the seventh postoperative day. He was eating three full meals a day and free of all symptoms, when he was discharged on the eleventh postoperative day.

Follow-up: The patient has been seen at intervals for the last year and now weighs 172 pounds as compared to his preoperative weight of 126 pounds. He is well and free of symptoms.

DISCUSSION

The predominant gastrointestinal symptoms encountered in this patient are in contrast to the respiratory signs of dyspnea, cough, and hemoptysis, sometimes met when a hollow viscus enters a diaphragmatic defect giving incarceration, obstruction, or strangulation. The complaints of this patient are commonly heard daily, the prolonged persistent studies exercised in this case being stimulated by the great weight loss. The history of a previous crushing chest injury (often forgotten by the patient), with a delayed onset of the gastrointestinal symptoms, might have caused an opinion that it was entirely unrelated to the anorexia, vomiting, and cachexia. Roentgenologic study directed attention to something other than an intrinsic gastrointestinal lesion, when repeated observations entirely ruled out the latter. Thus careful fluoroscopic and radiographic study of the diaphragm displayed the true causative deformity.

The left shoulder pain which extended down the left arm also related the left hemidiaphragm to the syndrome. The phrenic nerve, which is formed by the fourth, fifth, and sixth cervical segments, also contributes to the lateral trunk of the brachial plexus, which gives off the suprascapular nerve, the anterolateral thoracic nerve, and the musculocutaneous nerve. The pain originating in the left hemidiaphragm could thus be referred to the left shoulder and chest, and down the lateral aspect of the left arm, which is supplied by the musculocutaneous branch. This was precisely the pain distribution presented in this case.

SUMMARY

1. A syndrome of dysphagia, anorexia and cachexia due to a traumatic diaphragmatic hernia has been reported.

2. The mechanics, anatomical cause of the obstruction, and treatment has been discussed.

3. The necessity of thorough roentgenologic study with careful attention to the relations of the left diaphragm especially to subjacent organs is stressed.

4. A case report of this syndrome is reviewed.

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Acute Allergic Conditions Of the Abdomen

Obscure etiology frequently challenges the ingenuity of the doctor in his diagnosis of acute abdominal conditions, especially when he must decide whether the patient has an acute medical or an acute surgical disorder. The diagnosis may be made easier in some cases if it is kept in mind that an acute attack of the digestive tract may be the manifestation of a food allergy. Such attacks may simulate a perforating ulcer, gall bladder or renal colic, intestinal obstruction, acute pancreatitis, appendicitis, and coronary or mesenteric thrombosis.

For such acute allergic attacks I have used the term "acute allergic conditions of the abdomen." No doubt many emergencies which come to surgery, and in which no definite pathological lesion is found, represent this condition. The writer has never seen a patient with an acute allergic condition of the digestive tract who has not suffered from other definitely allergic conditions, such as seasonal or perennial hay fever, asthma, urticaria, eczema, migraine, or colitis, or given a positive family history of allergy. — F. B. Schutzbank, M. D., Tucson; *Arizona Medicine*, 9:32, October, 1952.

Diet in Cardiac Treatment

The diet taken by a patient with conorary artery disease is of importance. The patient who is overweight should be placed on a reduction program and encouraged to follow it until his weight has reached a normal level. This measure reduces the burden which the heart must bear and often is effective in reducing accompanying hypertension. Foods which cause indigestion and gastric distress should be avoided. The patient should never eat large meals or take large volumes of liquids at one time which produce a feeling of fullness.—Francis F. Rosenbaum, M. D., Milwaukee; *Wisconsin Med. J.*, 51:990 October, 1952.

Symptoms Suggesting Prodromal Stage of Diabetes Mellitus

O. P. ALLEN, M. D.

UP TO THE present time, there is very little information in the literature about the symptoms or conditions that precede the onset of the classical symptoms of diabetes mellitus.

With obesity being stressed as a sign predisposing to diabetes mellitus and most diabetics being overweight and, inasmuch as shortly after the onset of diabetes these patients begin to lose weight, it was thought wise to investigate this factor. Asking first when those patients with diabetes mellitus started to gain weight, and when they started to lose weight, gave a good idea as to the duration of the obesity.

Along with this information about obesity, we began to find these people were piecing between meals and at bedtime. Occasionally they would awaken after midnight and would be hungry or unable to go back to sleep. The reason for piecing and overeating was that they were hungry, weak, and sometimes cold,clammy, perspiring, and even trembling. All of the above symptoms give the idea of mild insulin shock. As would be expected, the ingestion of food relieved these symptoms, hence, the gain in weight, due to excess food necessary to relieve the shock symptoms.

The list of symptoms has grown. Both the gain and the loss of weight are usually preceded by some rather severe infection or a long continued toxic state which causes an imbalance in metabolic processes.

SYMPTOM COMPLEX

The symptom complex of the prodromal stage that is now looked for is as follows:

1. History of heredity or diabetes mellitus in the immediate family need not always be present.

2. An initiating toxemia or illness, either infectious or trumatic, followed by:

   A. Excessive gain in weight.

   B. Excessive appetite, piecing between meals, at bedtime or on waking during the night, relieves the patient of several of the following symptoms: (a) Hunger. (b) Weakness. (c) Nervousness or irritability. (d) Trembling and/or fluttering in epigastrium. (e) Sweating. (f) Night sweats. (g) Restless at night (inability to sleep and occasionally, hunger) with a history of raiding the icebox frequently obtained. (h) Dull, weak feeling or headache in morning before breakfast.

The above symptoms may be present from 1 to 25 years, more or less (an average of 12 years).

Submitted July 17, 1952.

The Author

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3. Another infectious or toxic period, soon followed by symptoms of diabetes mellitus:

   A. Loss of weight.
   B. Polyphagia.
   C. Polydipsia.
   D. Polyuria.

With part of the outlined picture in mind, 252 cases were reviewed in 1943 and the above symptom complex (items 1 & 2) found 24 per cent of the time. (See table I.) More careful histories were taken with these symptoms in mind and in the next 298 cases with some new symptoms and broader experience, this same complex was found in 33.5 per cent of the cases. (See table I.)

TABLE I

Year	History Number	Diabetic	Prodromal Stage	Per-Cent
1941 to 1943	1 to 500	252	61	24
1943 to 1945 July	501 to 1100	298	100	33.5
1945 to 1952	1101 to 2069	657	500	76.1
Totals				
1941 to 1952	1 to 2069	1207	661	54.77

Since 1945, with a better concept of what to look for, 657 cases have been examined up to July 1, 1952 and the group of symptoms listed under item 1 to 3 was found in 76.1 per cent of this number of cases. (See table I.) This gives an average, in 1207 cases, of 54.77 per cent, (see table I), and since 1945 no new symptoms have been added.

COMMENT AND DISCUSSION

It has been observed that infections, toxemias, or trauma, from whatever source, interfere with the effectiveness of insulin to oxidize glucose. This is especially true in the diabetic. This interference seems to be a destruction of, or a neutralization of insulin. When insulin is destroyed or neutralized, the normal pancreas, up to its maximum capacity, will overproduce, thereby making up the deficit needed to keep the concentration of glucose in the blood at normal levels. The overproduction is destroyed by the toxic

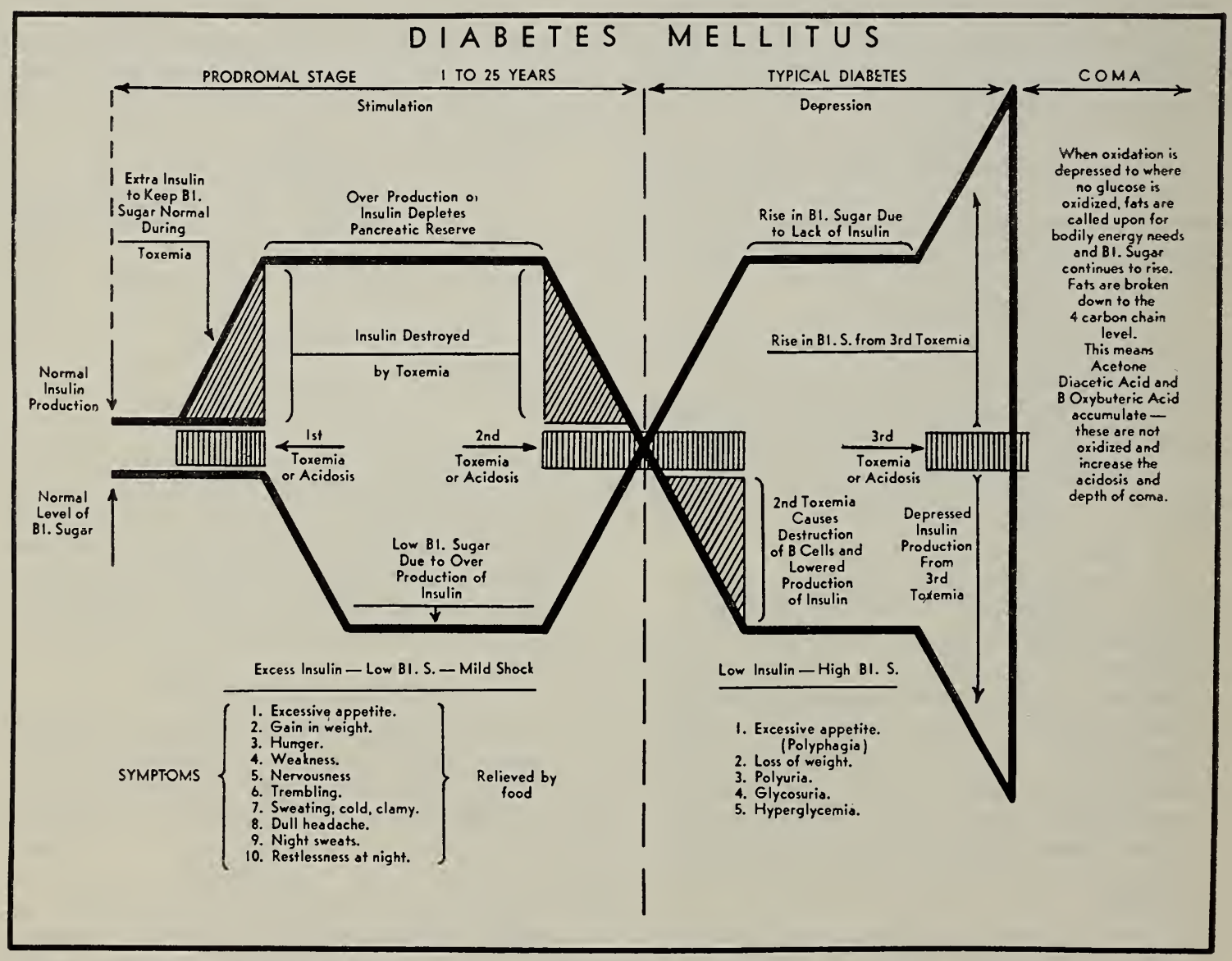
state from whatever source. The individual, with an hereditary background, does not have as great a maximum capacity or as wide a margin of safety, nor does he have the ability to produce large amounts of insulin above normal needs.

The capacity he does have is overworked and overstimulated and when the infection, toxemia, or insulin destroying factor disappears, the pancreatic islet cells, being overstimulated, continue to produce insulin in greater amounts than the normal metabolism demands. This individual is now getting an overdose of insulin. He therefore approaches hypoglycemic levels of blood sugar, and has an immediate increase in his desire for food to bring his blood concentration of glucose up to normal.

Under these circumstances, there being an overproduction of insulin with the resultant hypoglycemia, due to an excess insulin, the pituitary gland produces the anti-insulin factor to destroy the extra insulin. While the insulin is being destroyed by the anti-insulin factor, the diabetogenic factor is called into play to depress the islet cells to keep them from producing the excess of insulin. At the same time, the adrenal gland is brought into the attempt to restore normal balance by releasing glycogen from wherever stored to help bring the blood sugar level up to normal. However, the patient has an excess appetite and ingests food to relieve his hypoglycemia which starts the cycle all over again.

These patients remain in a state of low blood sugar or even hypoglycemic levels for months and sometimes years. Due to repeated infectious or toxic states, and when a prolonged or markedly severe infection or toxic state occurs, the overproduced insulin, which has kept the patient in a state of low blood sugar or even at hypoglycemic levels, is destroyed. The ability of the pancreas to produce insulin is reduced: first, by the toxic neutralization of insulin; secondly, by toxic damage to the islet cells, until not enough insulin can be produced to meet normal demands. The blood sugar mounts because of lack of insulin. Not enough insulin and a mounting blood sugar will soon produce the symptoms of positive stage of diabetes mellitus.

While collecting the above data we have used every completed history in our files. These include: first, the elderly patient who does not give a good history because of poor memory; secondly, also included are children who do not give good



The following is a diagram of what may be occurring as the metabolic disturbance progresses from a normal balance through an initiating upset, into a stage of overstimulation and overproduction of insulin; through a second stage of damage into a stage of depression and the developing of the symptom complex or metabolic dysfunction known as diabetes mellitus.

histories and are not well observed by parents. This should raise all percentages in all groups.

CASE REPORTS

Case 1. Mrs. ___, age 67. I first saw this patient in 1942, at which time she had been a known diabetic since 1935. The prodromal history starts in 1917 when she had tuberculosis and hemorrhage. In 1933, she had an abscess in the base of the spine and also had arthritis. In 1937 urinalysis revealed sugar. In 1933, the patient had rheumatic fever.

She had had all the usual childhood diseases—whooping cough, chickenpox, mumps and measles. History of diabetes in the family includes a cousin on the mother's side of the family and also a sister. The rest of the history is essentially negative, except for nocturia (once), and after tuberculosis in 1917 had a gain in weight of approximately 20 pounds.

From 1917 to 1933 the patient had the following negative phase symptoms: (1) Excessive appetite. (2) Gain in weight. (3) Weakness. (4) Sweating. (5) Night sweats. (6) Restlessness between 2 a. m. and 4 a. m These symptoms were relieved by ingestion of food.

After abscess on base of spine in 1933, this patient developed positive diabetes.

At the time of her physical examination, the temperature and pulse were normal. The blood pressure was 170/110, her weight was 141¼ pounds. The retinal examination showed more sclerosis than should be present at her age. The right ear shows old otitis media. Teeth have all been removed, otherwise the physical examination is essentially negative. Reflexes are depressed. The great toe on the right foot is missing, was removed in May of 1942.

Diagnosis: Diabetes, arteriosclerosis, low grade chronic nephritis, with a history of prodromal stage preceding the onset of diabetes.

Case 2. Mrs. ___, age 54, in 1918, had influenza following which she gained 75 pounds in weight within a period of one year. The next toxemia was in 1938 when abscessed teeth were extracted. In 1943 the patient had a severe sore throat and after recovery from it became thirsty all the time with frequent urination.

Between the years of 1920 and 1943, she had the following symptoms: (1) Excessive appetite, (2) Gain in weight, (3) Weakness, (4) Nervousness, (5) Sweating, (6) Cold and clammy, (7) Trembling, (8) Dull headache, (9) Dizzy, (10) Night sweats.

There is no familial history of diabetes and the rest of the history is essentially negative except for early childhood diseases.

The physical examination is essentially negative. Insulin doses are 58 units per day. Fasting blood sugars average between 126 and 144 mg. per 100 cc.

Case 3. Mrs. ___, age 59. One year ago, family doctor found sugar in urine. The patient was suspicious for three months because of loss of weight, drinking a lot of water, frequency of urination and weakness with a desire for food between meals. In 1920, the upper teeth were extracted following which she began to gain weight and up until 1946, with onset of menopause, there were two periods of major importance: that between 1920 and 1936, and between 1946 and 1951.

In the first period, she had upper teeth out in 1920; last pregnancy in 1925; and lower teeth extracted in 1936, following which there was a marked gain in weight. The second period starting in 1946 with onset of menopause, influenza in 1949 and development of diabetes in 1951.

Between these two periods she had the following symptoms: (1) Excessive appetite, (2) Gain in weight, (3) Weak, (4) Nervous, (5) Sweating, (6) Trembling, (7) Night sweats, (8) Restless at night, (9) Piecing between meals. These symptoms were relieved by food.

There is a familial history of diabetes of a brother, sister, and a cousin on father's side. Menstrual history is essentially negative, except the onset was quite late, age 15, which is common in diabetic women. The rest of the history is essentially negative.

Case 4. Mr. ___, age 18, first found he was a diabetic at the age of 11, in 1943. He was on protamine zinc (U40), 30 units in the evening. There is a familial history of diabetes. He was a full-term normal delivery, no instrumentation. Birth weight was nine pounds, five ounces. Mother had four children, this child was third pregnancy. Mother had nausea and vomiting with pregnancies, most severe with this child.

At age 4, in 1936, patient had measles and mumps and appendectomy; at the age of 11, abscessed teeth and tonsillectomy. Between 1936 and 1943, his appetite was excessive, he was moderately overweight—about ten to fifteen pounds—and he had the following symptoms: (1) Excessive appetite, (2) Piecing between meals and at bedtime, (3) Irritable when hungry, (4) Nervous before breakfast, (5) Butterflies in stomach. These symptoms were relieved by food.

The remainder of history is essentially negative and physical examination not remarkable.

CONCLUSIONS

(1) Diabetes mellitus is a state of depression of the organism to metabolize glucose and with a loss of weight.

(2) The depressed state follows a period of overstimulation, which has a typical syndrome of hypoglycemia and gain in weight, suggesting the overstimulation or overproduction of insulin.

(3) The period of overstimulation or overproduction of insulin may be mild or severe and lasts from 1 to 25 years—average 12 years.

(4) From data presented, an average of 54.77 per cent of 1207 patients present a prodromal stage. If the last 657 cases are considered, the percentage is actually over 75 per cent.

SUMMARY

The evidence presented offers the possibility in the beginning, of normal function in the metabolism of glucose and production of insulin. Due to stress and/or toxic states, the organism becomes overstimulated, and in this phase suggests the overproduction of insulin and hypoglycemic state which causes exhaustion of Beta cells of the pancreas due to an over demand for insulin. In this overworked state, these cells are easily damaged by a second or third or repeated toxic state and they become permanently damaged so that the production of insulin is far below the normal demand, and the organism loses its ability to metabolize glucose. The blood sugar rises above normal levels and we have the condition known as diabetes mellitus.

The Ohio Tuberculosis Hospital: First Year's Operation

R. H. BROWNING, M.D.

THE Ohio Tuberculosis Hospital opened its doors to patients on July 31, 1951. This new venture by the Department of Health of the State of Ohio has occasioned some interesting experiences and problems. It, therefore, seems worth while to present a report of the work done during the first 11 months of operation and to discuss briefly the relationships of this hospital to other tuberculosis hospitals in the State with mention of the services which are available.

The hospital was constructed to house 300 patients. It is well equipped and staffed for all types of diagnostic study of pulmonary disease and for major thoracic surgery. Located in the Health Center of Ohio State University, it serves as a teaching hospital for the College of Medicine.

One purpose of the Ohio Tuberculosis Hospital is to supplement other facilities in the State for the treatment of tuberculosis. Diagnostic and treatment facilities are offered to counties which have no tuberculosis hospitals of their own. Major surgery is offered to counties which have tuberculosis hospitals that are unable to provide for major surgery, and special diagnostic study of pulmonary cases, in which tuberculosis is a possibility, is offered to any citizen of Ohio.

The Author

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ADMISSION STATISTICS

The accompanying statistical report of activities for the period from July 31, 1951, through June 30, 1952, is illuminating in several respects. A total of 204 applications (Table I) were received from 60 of Ohio's 88 counties. To us, this is a surprisingly wide distribution of applicants and reflects an increasing understanding of this hospital's available service. Among the group admitted, there were 32 referred from other hospitals. Most of these came in after prolonged periods of care and were recommended for major surgical therapy, usually resection operations.

DIAGNOSES

Of the first 66 patients discharged, 30 per cent had nontuberculous lung disease. These included tumors, cysts, lung abscesses, bronchiectasis, and other less common pulmonary lesions (Table II). More recent experience suggests that the proportion of nontuberculous cases will average somewhat less than the 30 per cent shown above. It is probable that the figure will be between 15 and 20 per cent of all admissions.

The low death rate results in part from a careful selection of patients admitted. Generally speaking, because of the limited number of beds, those admitted have been suitable for definitive therapy. Hopeless, progressive cases have not ordinarily been accepted, though the hospital will have no reason to refuse such cases in the future when an adequate number of beds are in operation.

SURGICAL CONSIDERATIONS

A second explanation of the low death rate despite the performance of 58 major operations (Table III) is that these procedures have been done only after careful study and optimum preoperative preparation. Anesthesia is expert. Operative techniques are meticulous and postoperative care is given the close attention it deserves. Sufficient transfusion blood has been available from the Regional Blood Center of the Red Cross.

The surgical statistics reflect the current emphasis on resectional surgery as opposed to thoracoplasty operations. Most of the thoracoplasties were "tailoring operations" designed to collapse the chest wall to obliterate dead space remaining after resection. Four primary thoracoplasties were performed on patients whose disease contraindicated resection, either because of its distribution or lack of satisfactory stability.

DURATION OF STAY

The average stay of 94 days is, of course, much shorter than the usual duration found in county tuberculosis hospitals. Nationally, the average hospital stay of tuberculosis patients is about one year. The figure shown here reflects the care given to patients prior to admission here and also the fact that certain patients are returned to other hospitals for further treatment after surgery at the Ohio Tuberculosis Hospital.

THE CHANGING PATTERN OF TREATMENT

Table IV includes the record of laboratory examinations and totals of refills given in pneumothorax and pneumoperitoneum therapy. Here again, "the trend of the times" is evident. Pneumothorax, in disfavor because of pleural fluid complications has long since been surpassed in most areas by the simpler (and frequently less effective) pneumoperitoneum. Phrenic nerve paralysis, often used to improve pneumoperitoneum collapse in unilateral disease, carries the hazard of permanent diaphragmatic paralysis.

Submitted October 23, 1952.

This procedure, too, is being performed rather reluctantly and has fewer indications than formerly.

In addition to the changing relationships of the minor collapse therapy measures, the advent of effective chemotherapy has revolutionized many attitudes toward treatment. There is a growing tendency to treat acute or subacute pulmonary tuberculosis with bedrest and prolonged chemotherapy until maximum regression has occurred. After this, in suitable cases, major necrotic residues are resected.

All of these trends are reflected in the statistics presented here.

CHEMOTHERAPY

The commonly accepted regimen of streptomycin, 1 gram intramuscularly twice weekly, with sodium para-aminosalicylic acid (PAS), 12 grams daily in 4 doses of 6-0.5 gram tablets, is still the foundation of chemotherapy in tuberculosis. The PAS provides a great measure of protection against the emergence of streptomycin-resistant strains of tubercle bacilli.

Among the 46 tuberculous dischargees presented

TABLE I

Admissions and Discharges
July 31, 1951, to June 30, 1952

Total Applications Received from 60 Counties (1 to 10 patients each)		204
Applications accepted	169	
Applications rejected	27	
Applications pending or deferred	8	
CENSUS: June 30, 1952		
Total		88
Male	48	
Female	40	
ADMISSIONS		
Total		154
Male	82	
Female	72	
Admitted from other hospitals	32	
Admitted from home	122	
DISCHARGES		
Total		66
Male	34	
Female	32	
Discharged to other hospitals	17	
Discharged to home	48	
Deaths	1	
Average Stay of Discharged Patients—94 days		
DIAGNOSES OF DISCHARGED PATIENTS		
Tuberculosis		46
Minimal	6	
Moderately advanced	19	
Far advanced	20	
Tuberculosilicosis	1	
Other (non-tuberculous) (See Table II)		20

TABLE II

Discharges: Non-tuberculous
July 31, 1951, to June 30, 1952

Total Non-tuberculous Discharges		20
Abscess, lung, due to Friedlander's bacillus	1	
Abscess, lung, chronic	1	
Boeck's sarcoid	1	
Cystic bronchiectasis, right upper and middle lobes	1	
Bronchiectasis; infected pulmonary cyst	1	
Bronchiolar cyst	1	
Bronchitis, chronic	2	
Bronchogenic carcinoma	2	
Broncho-pleural-cutaneous fistula, left upper lobe, postoperative. (Pulmonary tuberculosis, inactive)	1	
Bullous emphysema	1	
Subpleural bleb	2	
Funnel chest deformity, congenital; chronic bronchitis	1	
Fibrothorax, empyema space, non-tuberculous	1	
Pulmonary fibrosis; bronchiectasis	1	
Silicosis	1	
Silicosis, conglomerate	1	
Pulmonary lesion, etiology unknown (tuberculosis?)	1	

TABLE III

Department of Surgery
July 31, 1951, to June 30, 1952

Total Operations			142
Major			55
Pneumonectomy		7	
Lobectomy		20	
Resection, segmental		5	
Resection, wedge		1	
Thoracoplasty		14	
Tailoring	6		
Primary (Two stages each)	4		
Thoracoplasty with removal of extrapleural pack		1	
Thoracoplasty with resection of scapula		1	
Thoracotomy with biopsy of lung		3	
Thoracotomy with removal of cyst of lung		1	
Pneumonolysis, closed		1	
Herniorrhaphy		1	
Operations performed in conjunction with the above procedures:			
Closure of two bronchopleural fistulas	1		
Resection of bronchopleural fistula	1		
Resection, segmental	4		
Resection, wedge	3		
Thoracoplasty, tailoring	4		
Minor			86
Phrenicotripsy		7	
Bronchoscopy		42	
Other		37	
Deliveries			1

TABLE IV

Departmental Statistics
July 31, 1951, to June 30, 1952

GENERAL LABORATORY		
Total specimens		5,378
Surgical specimens	85	
Other	5,293	
Total determinations		15,186
Autopsies		1
DEPARTMENT OF RADIOLOGY		
Total Examinations		1,616
Inpatient	1,187	
Outpatient	42	
Personnel	386	
RESEARCH LABORATORY		
Total procedures (Pulmonary function studies)		762
TREATMENTS		
Total		2,179
Initial pneumoperitoneum and refills	886	
Initial pneumothorax and refills	71	
Thoracentesis	46	
Fluoroscopic examinations	1,141	
Miscellaneous	35	

in this report, tubercle bacilli were cultured on admission in 38 cases. Of this number, four showed resistance to 100 mcg. of streptomycin per ml. of culture medium, 14 were partially resistant, while 19 were sensitive to 10 mcg. Results in one case are unknown. In at least some instances, the resistance resulted from injudicious administration of the drug. We are again impressed with the dictum that chemotherapy in tuberculosis is not an adequate treatment in itself, but should be combined with other measures in a long range program.

Isoniazid (isonicotinic acid hydrazide), after the flurry of publicity at the time of its announcement, is now being recognized as another useful and valuable adjunct in treatment. It is no "wonder drug" and resolves the tuberculosis problem no more than streptomycin does. The use of isoniazid at this hospital has been chiefly in patients whose organisms are streptomycin resistant.

DIAGNOSTIC AND SURGICAL APPROACHES

As examples of diagnostic and surgical procedures in current use, two case reports are presented. The first, Case A, was a problem for diagnosis which led finally to lung biopsy. The second, Case B, was an unusual case of tuberculosis requiring lobectomy and wedge resection.

CASE REPORTS

Case A: White Male, Age 37; Admitted September 7, 1951; Discharged October 21, 1951.

Past History: Prior to 1945, this patient had worked as an x-ray technician in industry for eight and one-half years. There was no history of exposure to harmful dusts. Survey chest x-ray film of April, 1950, showed diffuse nodular and linear lesions of both lungs. A diagnosis of tuberculosis was based on the x-ray findings. He was hospitalized in a tuberculosis sanatorium in September, 1950, where he received two short courses of streptomycin with para-aminosalicylic acid. Chest films were thought to show a cavity in the left apex. Tuberculin patch test was positive and one sputum smear was found positive for acid fast bacilli. His only symptom was slight shortness of breath. After an 11-month stay, he was discharged to his home and was admitted to the Ohio Tuberculosis Hospital one month later on September 7, 1951.

Physical examination revealed a few slightly enlarged cervical, axillary, and inguinal nodes, and moderate, diffuse enlargement of the thyroid gland. The left chest expanded poorly on inspiration. There was some dullness to percussion, with the presence of post-tussive rales and increased tactile fremitus over the left upper lung field. X-ray examinations (Figure I) revealed both lung fields to be the seat of diffuse linear shadows suggesting fibrosis. These were more prominent in the upper lung fields. There were a number of rarefied areas suggesting blebs or bullae. In the bases there were rather fine mottled shadows. The mediastinal shadow was widened at the level of the aortic arch. The left pleural sinus was obliterated. Films of the hands revealed normal findings.

Laboratory results included the following: Hemoglobin, 16.6 gms.; white blood cells 3,300; neutrophils 67 per cent; eosinophils 7 per cent; lymphocytes 25 per cent; basophils 1 per cent; red blood cell sedimentation rate (Wintrobe) 10 mm. per hr.; blood Kahn negative; serum total protein 7.29 gm.; albumin 4.23 gms.; globulin 3.06 gm. Normal urine. Tuberculin test positive to P.P.D. (purified protein derivative) No. 2. Coccidioidin and histoplasmin skin tests, negative. Sputum concentrations and cultures of gastric contents negative for tubercle bacilli, fungi, and other pathogenic organisms.

Lymph node removed from right axilla showed no abnormality grossly or microscopically. Cultures of the node showed no growth of acid fast bacilli or fungi.

A lung biopsy specimen removed from the right lower lobe on October 4, 1951, showed typical

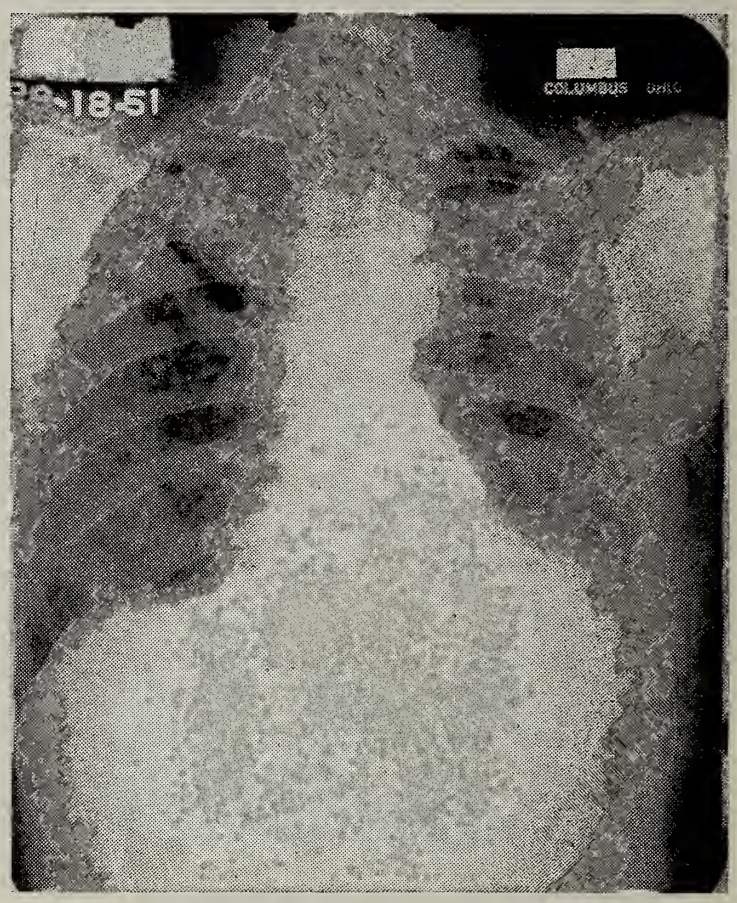


Fig. I. Case A, September 18, 1951

findings of sarcoid on microscopical examination. Chemical analysis of the specimen was negative for beryllium.

It was thought that the sarcoidosis was of long standing and that it had caused the fibrous changes observed. The presence of tuberculosis was possible but unlikely since the single reported positive sputum could not be confirmed.

Case B: White Male, Age 42; Admitted October 3, 1951; Discharged January 9, 1952.

Past History: The patient had a small hemoptysis in 1927. This was accompanied by a sharp pain under the left shoulder, and followed a period of severe exercise. There was no history of direct exposure to tuberculosis. He was known to have a "calcified density" in the left lower lung field since x-ray examination in 1939. A film dated January, 1948 (Figure II), showed a sharply circumscribed, dense, oval shadow in the left lung field. This contained a number of small, calcified flecks and nodules. A definite diagnosis of tuberculosis was made in May, 1949, when acid fast bacilli were found in the sputum for the first time. In May, 1949, there was a change in the x-ray appearance (Figure III). The previously described nodule was partially emptied

with a fluid level remaining about 1½ cm. from the bottom. In addition, a zone of soft infiltration was seen extending from the hilum into the mid lung region on the left.

In June, 1949, he entered another tuberculosis hospital, had pneumoperitoneum therapy started, and received a left phrenic nerve crush. He was discharged to his home in January, 1950, after having had intermittent chemotherapy with streptomycin and PAS (para-aminosalicylic acid). Following this, his sputum was occasionally positive for acid fast bacilli. These findings and an increase in symptoms led to admission to the Ohio Tuberculosis Hospital.

Physical Examination: On admission, there were no positive physical findings except for the evidence of pneumoperitoneum. X-ray examination of October 5, 1951 (Figure IV), showed clearing of the previously described shadows. Multiple small calcifications remained in the left lower lung field. A rather large pneumoperitoneum produced a considerable degree of elevation of both leaves of the diaphragm, especially the left.

Laboratory findings revealed three admission

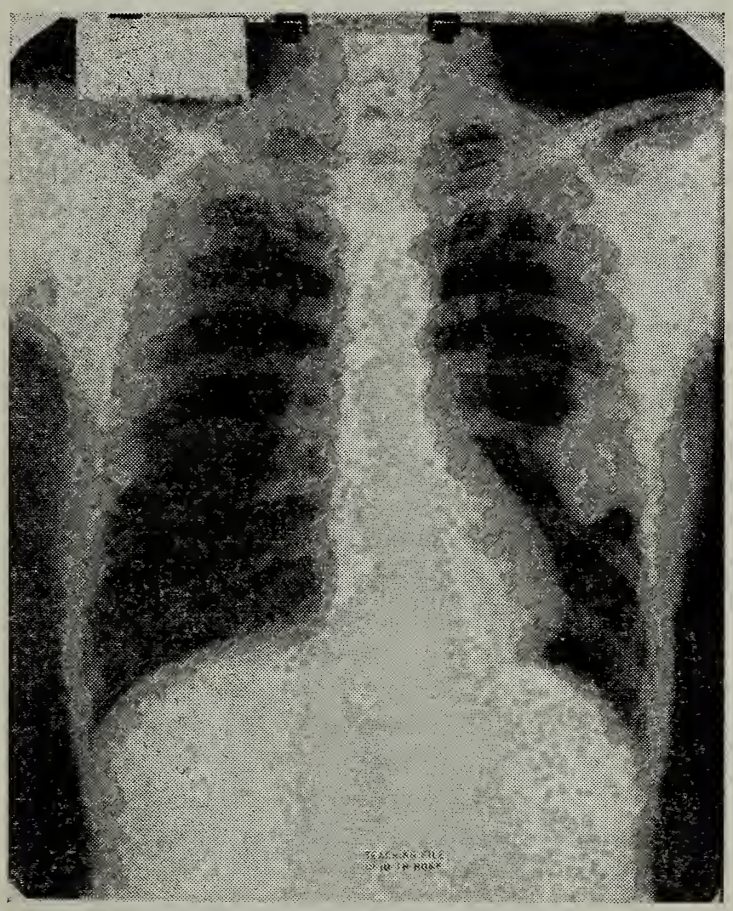


Fig. II. Case B, January, 1948

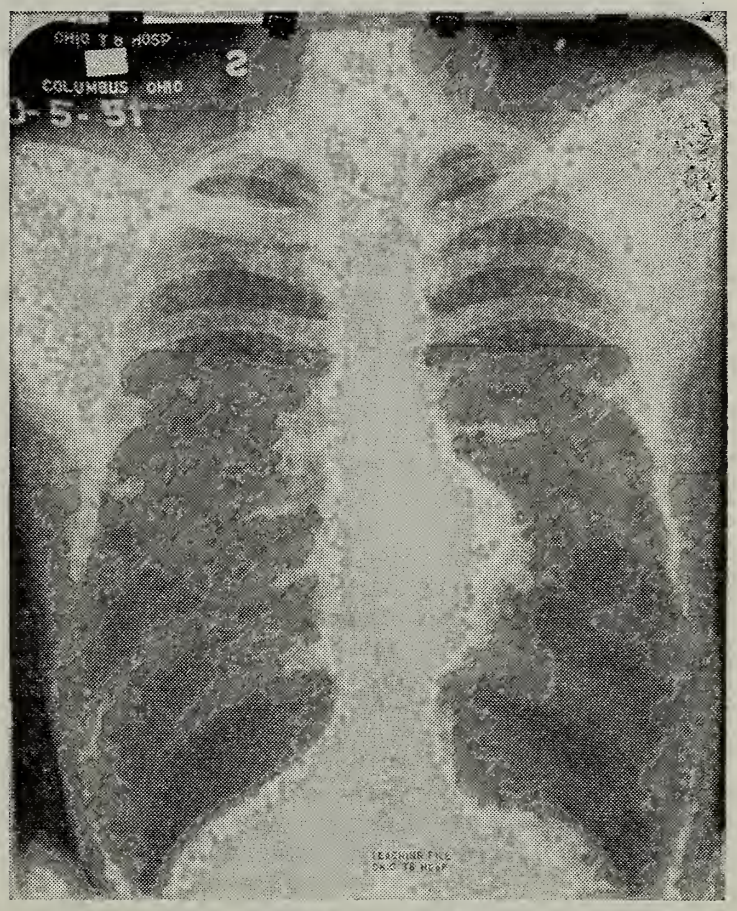


Fig. IV. Case B, October 5, 1951

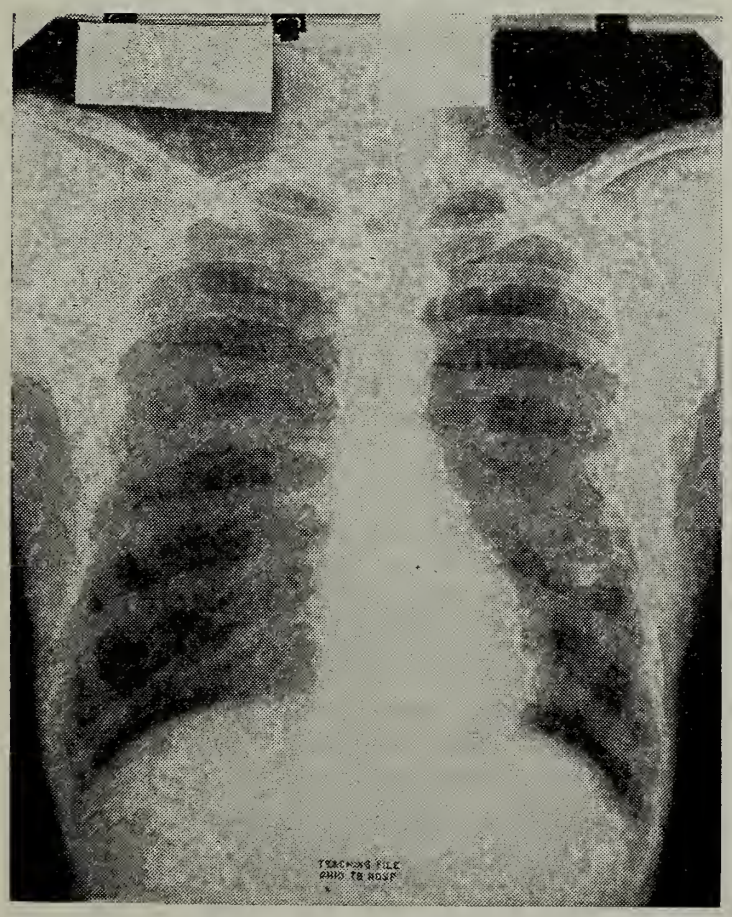


Fig. III. Case B, May, 1949

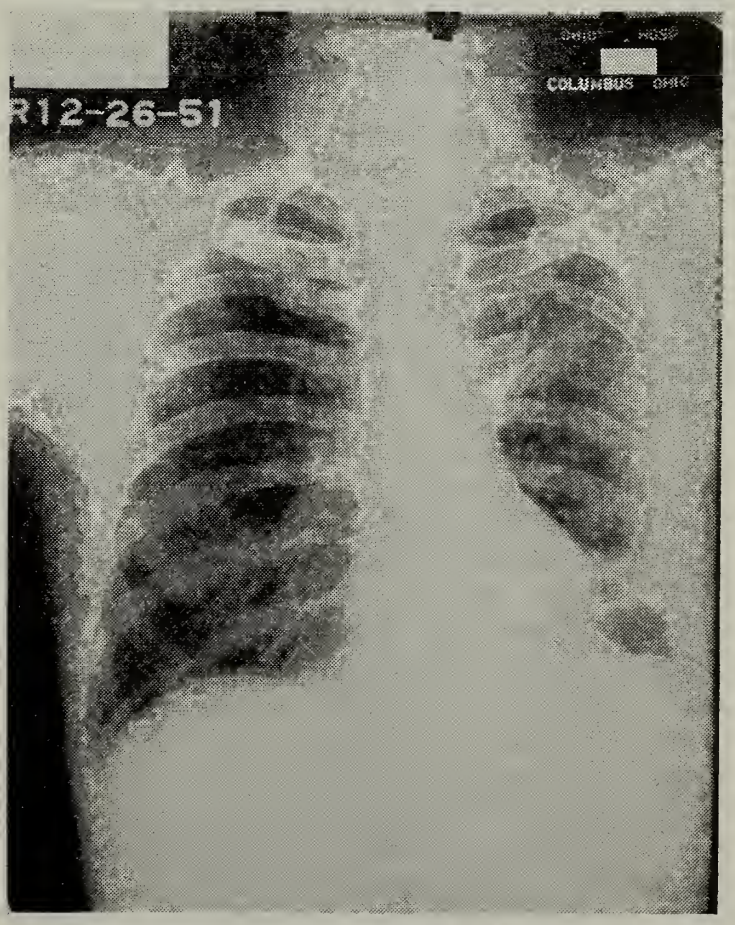


Fig. V. Case B, December 26, 1951

specimens of sputum to contain typical tubercle bacilli on culture. Pulmonary function studies were as follows:

	November 9, 1951 Pre-operative	January 7, 1952 Post-operative
Minute Ventilation (Resting)	5.2 L/min/m²@ 37°	4.38 L/min/m²@ 37°
Walking Ventilation	7.7 L/min/m²@ 37°	9.9 L/min/m²@ 37°
Max. Breathing Capacity	63.3 L/min/m²@ 37°	57.2 L/min/m²@ 37°
Max. Breathing Capacity—per cent of estimated normal (Cournand)	98%	93%
Walking Index	12%	17.3%

Despite the absence of visible cavity in the admission x-ray film, the presence of tubercle bacilli in the sputum and the history of the case led the staff at Surgical Conference to a recommendation for left lower lobectomy. The patient was considered to be in excellent condition. Pulmonary function studies were satisfactory.

Operation: A left lower lobectomy was performed on November 13, 1951. Because of the involvement of the lingula of the left upper lobe, a small wedge resection was performed in this area. The patient tolerated the operation well. He had a measured blood loss of a little over 2,000 cc. and received five pints of blood in the operating room. His recovery was uncomplicated.

Postoperative film of December, 1951 (Figure V), shows defects in the 5th and 6th ribs on the left. There is pleural thickening at the base. The diseased area is no longer seen. The right lung field is clear. Subsequent films to Oct., 1952, have revealed no change and he is in a good state of health. Chemotherapy is being continued.

Examination of the specimen showed typical findings of chronic tuberculosis. A flattened cavity measuring 2 cm. in its greatest diameter was found in the superior segment of the left lower lobe. It had a thin hemorrhagic wall and was lined with necrotic material. There was scattered chronic disease elsewhere in the lower lobe.

It was thought that the major lesion represented a circumscribed area of caseous pneumonic disease ("tuberculoma") or a filled cavity. The removal of almost all of the visible disease including the area of cavitation would appear to offer him a great measure of assurance for future good health.

EXTRA-CLINICAL SERVICES

A program of Occupational Therapy and library service has been established. This, along with the four channel radio system and a Sunday religious service has done much for the morale of the patient group.

A vocational counsellor is being sought to carry out aptitude testing and vocational guidance among patients needing these services.

A great variety of social and economic problems appears during prolonged hospital care, especially when the patient is far from home. Trained medical social workers are available to aid in resolving such problems. Frequently, there are psychological overtones which require cooperative action by physician and social worker.

The Social Service Department is responsible also for making necessary arrangements for the discharge of patients. These involve financial support, medical supervision, housing, and other aspects of the patient's life which may make or break his future health.

To assist in maintaining understanding and cooperative action between the Ohio Tuberculosis Hospital and health agencies in the patient's home area, a nurse consultant in tuberculosis has been appointed. One of her responsibilities is to interpret personally the recommended treatment program of the patient so that the possibility of relapse after discharge is minimized.

OTHER RESPONSIBILITIES OF THE HOSPITAL

The Ohio Tuberculosis Hospital located on the campus as part of the Health Center of Ohio State University provides teaching facilities for chest diseases which are equalled in few medical schools. The College of Medicine with its expanding classes (now admitting 150 students in each Freshman class) is using the Ohio Tuberculosis Hospital and its staff for the teaching of chest diseases. Each member of the Junior Class has a ten-day clerkship at the hospital and each member of the Senior Class spends three half-days in the combined medical-surgical chest clinic of the outpatient department during the year. In addition, there are lectures, conferences, and clinics in which tuberculosis and other chest problems are presented.

Supplementing the annually appointed resident staff, all interns from the University Hospital have one month of experience in rotation at the Ohio Tuberculosis Hospital. Assistant residents from the medical service serve two months each during the year. Approval of the residency training program in pulmonary disease was granted by The Council on Medical Education and Hospitals of the A. M. A. this year.

ADMITTING PROCEDURE

Application for admission is made on a special form submitted to the hospital by the patient's physician. By law, the application must have the approval of the board of county commissioners of the patient's county of residence. Patients who are able to pay for their hospital care are accepted, but receive the same care as other patients. All billings for hospital care are sent to the boards of county commissioners. Any payment by the patient is made to the board, not to the hospital. The current net billing to counties is at the rate of $7.25 per diem.

The problem of attaining an adequate number of registered nurses has persisted from the beginning until the present time. This has limited the number of beds which could be made available. As of October 1, 1952, five of the Hospital's ten 30-bed divisions have been opened. It appears currently that there will be a steady increase in the number of beds available since more nurses are applying than in earlier months.

Acknowledgment: Thanks are due to Neil C. Andrews, M. D., chief of surgery, for helpful suggestions, and to Miss Ruth M. Wood, R. R. L., and Mrs. Janet G. Bettes for statistical and other assistance.

Hereditary Spherocytic Anemia in a Negro Family

HENRY J. CAES, M. D., JEROME H. MEYER, M. D., MALCOLM BLOCK, M. D., and RAYMOND M. KAHN, M. D.

HEREDITARY spherocytic anemia is infrequently reported in the Negro. Butterworth et al.[1] reported only 14 cases occurring during the six years prior to the publication of their report of 12 persons in four generations, two with spherocytic anemia, five normal, and five apparent carriers. Goodman and Cates[2] reviewed the literature to 1947 and found only eight reported cases and reported three of their own.

Because of the rarity of this disease in the Negro as compared with the white race, the occurrence of the disease in a Negro family of eight is reported.

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CASE REPORTS

Case I, a married negress, age 24 years, the daughter of patient reported in Case II. She was first admitted to the hospital as a surgical emergency on February 21, 1950, with the chief complaint of pain in the lower abdomen. She had had pain for the previous three weeks which became worse just before admission, and a foul vaginal discharge for three weeks.

Physical examination revealed an enlarged tender mass in the right adnexal region. No other abdominal masses were palpable, nor was the spleen felt. A clinical diagnosis of twisted ovarian cyst was made. At operation on February 22nd there were found a massive bilateral hydrosalpinx and inflammatory cysts of both ovaries with severe fibrous pelvic adhesions. The patient was discharged improved on March 9, 1950.

Laboratory findings were as follows: red blood cells 2,740,000, hemoglobin 8.5 grams (Haden-Hauser), white blood cells 8,700, segmented cells 73, bands 10, lymphocytes 17. Smears showed spherocytes, anisocytosis and polychromatophilia. The osmotic erythrocyte fragility tests[3] showed the patient with beginning hemolysis at 0.54 and complete at 0.36, the control beginning at 0.46 and completed at 0.34. The reticulocyte count was up to 6.5 per cent. The quantitative serum bilirubin was 1 minute direct 1.6 mg. per 100 cc. and total bilirubin 2.0 mg. per 100 cc. The two hour urine urobilinogen was 1.30 mg. (normal 0.25 mg.). The quantitative urobilinogen of an occasional fecal specimen was over 150 mg. per 100 grams of stool (normal 70-150). Coomb's tests (direct and indirect) were negative; Donath-Landsteiner tests were negative. The patient's serologic studies on a subsequent admission showed reaction to Kline cardiolipin test two plus, Kahn standard one plus, and Mazzini three plus. Blood cultures were negative. A chest x-ray showed normal findings. An electro-cardiogram revealed evidence of "coronary insufficiency (acute transitory)."

Splenectomy Refused. The patient received five transfusions with no unusual reactions and was discharged from the hospital with a red blood cell count of 3,810,000, hemoglobin of 10.5 grams. She was advised to have a splenectomy which she has refused to date. Her family was investigated and the findings are summarized in table I. Only her mother (Case II) has permitted splenectomy.

Hospital Readmission. On March 17, 1950, the patient (Case I) was readmitted to the hospital for intestinal obstruction due to postoperative adhesions and a cul-de-sac abscess. During the operation for relief of the obstruction, the spleen was found to be normal in size.

On this admission, red blood cell count was 4,090,000, the hemoglobin 11.5 grams, the white blood count 13,100 with 80 per cent segmented cells, 12 per cent band form cells, and 8 per cent lymphocytes. By March 23rd her red blood count fell to 2,680,000 and the hemoglobin to 7.5 grams. Five transfusions were given without reactions and she was discharged from the hospital on April 12, 1950, with a red blood count at 3,810,000 and hemoglobin 11.5 grams. The two hour urine urobilinogen was 3.5 mg. and the bile tests were negative.

Diagnosis of spherocytic anemia was made and the family was examined. The father refused examination. As seen in table I, the mother and four of the six children showed the positive findings of spherocytic hemolytic anemia. The tests for sickle cells were all repeatedly negative. Splenectomy was advised, especially for the two children with the severe anemia. The mother permitted the operation on herself only. (See Case II report.)

Case II, a 48 year old colored married multipara was admitted to the hospital on July 26, 1951. The chief complaints were swelling of her legs, pain in her upper abdomen, and a severe "cold." The onset of the cold was July 21, 1951, at which time she also noted that her urine was deep orange in color. She knew of her enlarged spleen, discovered after a routine physical examination of the family, prompted by an acute hemolytic crisis in her daughter (Case I).

Past history revealed no serious illnesses, injuries nor operations. She had had six full term pregnancies, and all children are living.

Family history revealed that she was born in Georgia. Her father is 73 years old and is well. Her mother died at the age of 32 years, after

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having had 12 children. The last five, all boys, died in infancy. The patient states that she definitely recalls that one of the infants had "yellow eyeballs." Her only sister died in January, 1952, of "cancer." There are six brothers, living and well. The family history of the patient's children is summarized in table I.

per cent to 1.3 per cent; fecal urobilinogen 65 mg. per 100 grams (260 E. U.) on August 6, 1951, to 15 mg. per 100 grams (60 E. U.) on August 13th; urine urobilinogen 0.05 mg. and 0.1 mg. per 100 cc. on two occasions; serum bilirubin direct—1 minute 0.21 mg. per 100 ml. and total bilirubin 0.70 mg.; erythrocyte fragility test on

TABLE I. LABORATORY DATA ON MEMBERS OF FAMILY

Relationship	Age Yrs.	RBC x 10^6	Hemoglobin Gms.	Retic. %	Spherocytes	Urine Urobilinogen mg. %—2 hrs.	Fragility	Serum Bilirubin Total Ind. Mg. %	Serologic Tests for Syphilis	P. T. *
Mother—Case No. 2	44	3.25	9.5	4.7	+	0.50	Hemolysis Begins at 0.62 Completed—0.36	2.8	Neg.	100
Daughter—Case No. 1	24	3.8	11	1.8	+	3.5	Begins at 0.56 Completed—0.36	1.15	Pos.	90
Son	22	546	15.5	0.7	0	0.10	Begins at 0.44 Completed—0.32	1.25	Neg.	100
Daughter	15	2.7	8.5	1.2	+	0.45	Begins at 0.60 Completed—0.36	2.5	Neg.	56
Son	10	4.62	13.5	0.8	0	0.15	Begins at 0.42 Completed—0.32	1.1	Neg.	100
Son	12	1.76	5.5	0.1	+	0.65	Begins at 0.52 Completed—0.40	2.45	Dbt.	100
Son	8	3.78	10.5	1.3	+	0.25	Begins at 0.60 Completed—0.40	1.75	Neg.	80
Father	48	Refused Examination								
Control							Begins at 0.44 Completed at 0.34			

Sickle Cell Tests—all negative. Palpable Spleen—palpable mother only.

* P. T.=Prothrombin Time—% of normal.

The patient is adamant in the statement that in the recollection of the family there were no members of any other race but the black race. However, her family history dating before her own grandparents is uncertain. The patient, on being presented with a list of congenital anomolies, denied their presence in the members of her family. A physical examination of her children later failed to reveal any.

Physical examination of the patient revealed somewhat icteric sclera, and spleen palpable to two finger breadths below the left costal margin. The preoperative laboratory findings on July 27, 1951 were: hemoglobin 62 per cent, erythrocytes 2,900,000, white blood cells 5,000 with 69 segmented cells, and 30 lymphocytes, reticulocytes 4.7 per cent. The blood smears revealed a slight anisocytosis, microcytosis and many spherocytes The fecal urobilinogen was over 50 mg. per 100 grams; serum bilirubin direct 1 minute 0.0, total bilirubin 1.40 mg. per 100 ml.; urine urobilinogen July 30th, 0.11 mg. per 100 cc. for 2 hour specimen, 0.4 Ehrlich units; icteric index 12 units; erythrocyte fragility test, control-hemolysis beginning at 0.46 per cent, complete at 0.32 per cent; patient-hemolysis beginning at 0.64 per cent, complete at 0.38 per cent; serum proteins 6.55 gms. per 100 ml. A:G ratio-1.28:1; thymol turbidity 3.5 units; cephalin flocculation-1 plus, 48 hrs.; bromsulfalein test 7.2 per cent at 15 minutes, 2.5 per cent at 45 minutes retained; serum total cholesterol-156 mg. per 100 cc.; coagulation time, 5 minutes and 40 seconds (capillary); sickling test negative.

The erythrocyte count rose from the first postoperative day on August 3, 1951, from 3,510,000 to 4,000,000 on December 4th; platelet count from 273,750 to 516,880; reticulocyte count from 0.6 August 7th showed hemolysis beginning at 0.60 per cent and complete at 0.32 per cent and on December 4, 1951, showed hemolysis beginning at 0.44 per cent and complete at 0.28 per cent; icteric index September 4, 1951, 5 units.

At present the patient is well and shows occasional spherocytes in blood smears. A review of the members of the family living in this vicinity, including those listed in table I, showed them to be dark-skinned Negroes with pronounced features, typical of that race. The father of the reported family refused to be examined or questioned.

DISCUSSION

The diagnosis of familial spherocytic anemia in this family of eight was based on the typical findings of familial incidence—anemia, acholuric jaundice, spherocytosis and increased osmotic erythrocyte fragility. None showed any sickling tendency. Although it is unfortunate that the father refused examination, it appears that the mother of the family possesses the necessary genetic structure for transmission of the disease, since it is likely that the disease is transmitted as a dominant Mendelian factor. Further genetic study could not be accomplished because of the inability to locate distant relatives and the refusal of the father to be examined. It is to be noted that in this family of eight, the mother and four children have active hemolytic anemia while two of the children appear normal.

Mersky,[4] who reported a case in an African

native, stated that he could not find a similar case report in an African native to that date. Hodges[5] in a study of racial mixtures upon erythrocyte sickling showed from the work of Seligman[6] the limited regions containing "pure" Negroes in Africa. This work also showed the various possibilities of racial dilution. From the foregoing it is seen that since the disease is uncommon in American Negroes, and extremely rare in the African native, that miscegenation could account for the appearance of this disease in the Negro and transmitted to offspring in the same manner.

SUMMARY

1. A negro family of eight is reported in which five members, the mother and four children, have congenital hemolytic spherocytic anemia.
2. All the members observed had no other detectable congenital anomalies.
3. All the members of the family show strong negroid characteristics but miscegenation is probably the reason for the appearance of this disease in the Negro.
4. One of the members was successfully treated by splenectomy.
5. Hereditary spherocytic anemia is rare in the American Negro although more common than in the African native.

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Polio—Pathogenesis and Prophylaxis With Use of Gamma Globulin

Preliminary reports indicate that Red Cross gamma globulin provides significant protection against paralytic poliomyelitis. These experiments provide the first definitive evidence that passively transferred antibody can alter the course of the disease in human beings. It should be recognized that a vast amount of work in experimental animals preceded and made possible the human experiment.

Major developments in poliomyelitis research in recent years include (1) the recognition of three distinct immunologic types of virus, (2) the importance of viremia in the pathogenesis of the disease, (3) the growth of poliomyelitis virus in tissue culture and (4) the protective effect of antibodies in experimental animals, whether passively transferred or induced by vaccines. These findings and many others based on the work of numerous investigators have led to an altered concept of the pathogenesis of poliomyelitis.—William Friedewald, M. D., Atlanta; *J. M. A. Georgia*, 42:9, January, 1953.

Some Consequences of Depletion Of Sodium Chloride

In simple dehydration from lack of water alone the extracellular fluid and blood volumes are largely maintained; circulatory failure usually does not occur until very late. Because of the primary dehydration the extracellular fluids tend to become hypertonic. On the other hand when salt depletion occurs, the extracellular fluid becomes hypotonic from loss of electrolyte (exemplified by hypochloremia and hyponatremia) and marked contraction of this space occurs. The blood volume falls and peripheral vascular collapse ensues. The kidney, at least for a time, continues to excrete water (about 500 to 700 milliliters per day) in an effort to maintain the tonicity of the body fluids. For this reason the record of the output of urine may appear fairly good even though the patient is becoming progressively worse. . . .

But, as the salt depletion and circulatory failure worsen, renal function is impaired, nitrogenous products accumulate in the blood, and oliguria or even anuria may develop. Death, under these circumstances, is usually attributed to "uremia" or "circulatory failure" while, in reality, the individual dies merely from a lack of salt.

Because hypertonicity is the stimulus for the development of the sensation of thirst, it is clear why the salt-depleted patient is not thirsty. He may be severely dehydrated as a secondary consequence to the lack of salt, but his body fluids are hypotonic. Thus in dehydration where salt losses have been greater than water losses, the lack of thirst cannot be taken to mean that the patient does not need water, as well as salt. The sensation of thirst is a protective device for simple lack of water; no such device exists for lack of sodium chloride.—William W. Engstrom, M. D., Wauwatosa; *Wisconsin M. J.*, 51:1078, November, 1952.

Local Treatment of Infantile Eczema In Infants and Children

Lannalan may be easily prepared in lotion, ointment, or paste forms. This medication is particularly useful by virtue of its employment in the fairly acute phases without dangers of irritation, folliculitis, or toxicity. The preparation used in the children's department has the following composition:

	Gm. or C. C.
Lannalan	5.00
Zinc Oxide	25.00
Boric Acid Ointment 10%	60.00
Liquid petrolatum	10.00

This preparation is used after the infection has subsided and acute phase has responded to the wet dressings.—William N. Slinger, M. D., and Stig Hard, M. D., Rockford; *Illinois M. J.*, 102:312, November, 1952.



Case Record

From the
Institute of Pathology, Western Reserve University, and University Hospitals of Cleveland

Edited Under the Auspices of the Ohio Society of Pathologists

Robert Ritterhoff, M. D., President

Presented by D. G. Johnston and John Morledge

PATIENT ....., a white male, age 53 years, was admitted to University Hospitals on November 18, 1950, with complaints of right upper abdominal pain, nausea, vomiting, and constipation of four days' duration. Fever had been present for an unknown period. In addition, he had developed a cough, productive of large amounts of thick yellow sputum, over a three-month period.

Six weeks prior to admission he had suddenly developed an inordinate thirst, accompanied by copious polyuria. His fluid intake had increased to "three to four gallons of water, eight to ten cokes and twelve beers per day." For an equal period of time the patient had experienced difficulty in swallowing which had become progressively more severe. He had received intensive penicillin therapy for syphilis two years before admission, and the serology was said to have become negative.

Admission physical findings were: Temperature 39.3°C., pulse 60, respiration 30, blood pressure 120/70. There was an increase in the antero-posterior diameter of the chest, with amphoric breath sounds over the right apex. There were no areas of dullness to percussion; no rales or rhonchi were heard. Eyes, ears, nose and throat were negative. The trachea was in midline. Right upper quadrant abdominal tenderness was present; there were no palpable abdominal masses. The heart was normal.

Laboratory studies revealed white blood cells 16,700; differential—80 per cent neutrophils, 12 per cent lymphocytes, 7 per cent monocytes and 1 per cent eosinophils; red blood cells 4.29 million, hemoglobin 11.8 Gm., Hematocrit 42 per cent, erythrocytic sedimentation rate — corrected to 37 mm. per hour, blood urea nitrogen 15 mgm. per 100 cc., chlorides 100 mEq. per liter, CO_2 combining power 52 volume per cent, cephalin flocculation 1 plus, thymol turbidity 0.4 units, serum proteins 6.4 gm., albumin 4.4 gm., globulin 2.0 gm., Kline exclusion 2 plus, diagnostic 1 plus, titre 1:10 negative, Wassermann negative. Spinal tap showed opening/closing pressures 210/110, 1 monocytic cell per cu. mm., negative Pandy and Ross-Jones. Protein 24 mgm. per 100 cc., chloride 119 mgm. per 100 cc., sugar 79 mgm. per 100 cc., Wassermann and mastic negative.

Diagnosis of diabetes inspidus was made immediately and, because of the patient's distress, treatment was begun before the results of laboratory tests were known. To the time of death, the symptoms of diabetes insipidus were controlled by nasal insufflation of posterior pituitary powder. Urinalysis after treatment revealed no abnormalities.

The patient became severely dyspneic on the third hospital day. This was relieved by oxygen. Chest films on November 18, 1950, showed streaked shadows of the upper lobe of the left lung. On November 22nd, an extensive area of pneumonic infiltration was seen extending laterally about the left hilar area. There was a shadow in the upper lobe of the right lung. A film on November 28, 1950, showed slight clearing of the left lung lesion. The patient was treated with penicillin. Swallowing became progressively more difficult, and barium studies revealed partial esophageal obstruction at the level of the tracheal bifurcation, which appeared to be extrinsic.

On the 24th hospital day, esophagoscopy and bronchoscopy were performed, and an extrinsic compression of the midportion of the esophagus was seen, with no abnormalities of the esophageal mucosa. Bronchoscopy revealed only slight inflammatory changes in the smaller bronchial branches. Aspirations were negative for acid-fast bacilli and Papanicolaou cell studies were

negative. Repeated sputum smears were negative for acid-fast bacilli; guinea pig inoculations were negative. Skull and bone films were negative. On December 21, 1950, the esophagus was dilated by the Plummer method, with subsequent clinical improvement.

Treatment: The patient received penicillin for the first three weeks. The erythrocytic sedimentation rate, white blood count, and temperature returned to normal. Streptomycin was started on the 21st hospital day. On the 34th hospital day, he was discharged with persistent expectoration and cough, to be maintained on streptomycin and posterior pituitary powder.

Hospital Readmission: He was re-admitted to Ear, Nose and Throat Service January 5, 1951, for removal of impacted food from esophagus. The esophagus was again dilated and he was discharged after two days. Sputum was again negative for acid-fast bacilli.

Third Hospital Admission: He entered the hospital for the third time on February 27, 1951, with complaints of increasing dysphagia, increasing cough, marked anorexia and a ten pound weight loss in the past three months. The patient was poorly nourished and of wasted appearance. Temperature 37.8°C., pulse 96, respiration 20, blood pressure 125/80. Positive physical findings were limited to dullness and decreased breath sounds over both apices, firm palpable left axillary nodes, and a firm palpable liver two finger breadths below the costal border.

Laboratory Findings: Alkaline phosphatase 6.6 units, serum protein 6.8 Gm., albumin 4.1, globulin 2.7, sedimentation rate 37 mm. per hour.

Serial electrocardiograms revealed a "changing myocardial process." Chest x-rays revealed an infiltrative pneumonic lesion in the left upper lobe, similar to that seen previously. Bronchoscopy revealed an intraluminal compression of the trachea posteriorly, just above the carina. There was edema and narrowing of the left main stem bronchus. Aspirations were negative for tuberculosis cells and for malignant tumor cells. Films of the lumbar spine showed slight wedging of T-12. Biopsy of bronchial mucosa showed subacute and chronic bronchitis. An axillary node biopsy revealed acute lymphadenitis. He was given penicillin, and discharged improved on the 25th hospital day.

Fourth and Fifth Admissions: He was admitted a fourth time April 7, 1951, with above complaints and with increasing constipation. X-ray revealed pathologic fractures of L-1, T-12 and a nodular shadow in region of the right 4th rib. Skull films were negative. He was discharged after 21 days. The fifth admission was May 9, 1951. Lumbar pain was so severe that morphine was constantly required. He was given one dose of nitrogen mustard with considerable clinical improvement. X-ray showed some streaked shadows in the left lung. There was progressive collapse of T-12 and L-1. Blood calcium 9.5 mgm. per 100 cc., phosphorus 4.1 mgm. per 100 cc., alkaline phosphatase 3.1. Acid-fast stains of sputum were negative. Malignant tumor cells were not identified in sputum. He was discharged in poor condition after 38 days. He again received penicillin.

Sixth Hospital Admission: On the sixth admission, July 18, 1951, he was very emaciated. He had a complete flaccid paralysis of the right leg with diminished sensory perception and absent vibratory and position senses. Chest x-ray showed no change in the lungs. Electrocardiogram showed changes consistent with an anterior myocardial infarct. He was in considerable pain, frequently irrational, and was constantly sedated until death one month later.

The clinical diagnosis was bronchogenic carcinoma with metastasis and diabetes insipidus.

Autopsy examination disclosed marked emaciation. There was a poorly differentiated adenocarcinoma of the apex of the right lung which had invaded the right 3rd and 4th ribs and thoracic vertebrae at the costovertebral joints. Similar carcinoma was present throughout all lobes of both lungs, mediastinal lymph nodes, skull, T-12 and L-1 vertebrae, left kidney, adrenals, posterior pituitary and hypothalamus.

There was marked compression of the esophagus by metastatic carcinoma in lymph nodes at the bifurcation of the trachea. There were compression fractures with herniation of the nucleus pulposus of vertebrae T-12 and L-1. There was a calcified primary tuberculous complex involving the upper lobe of the right lung and a right parabronchial lymph node. There were no abnormalities of the heart. A fusiform aneurysm with thrombus formation was present in the abdominal aorta.

DISCUSSION

The clinical aspect was discussed at a Clinical Pathological Conference held in September, 1951, by Dr. Curtis Garvin who considered diabetes insipidus, mediastinal mass, vertebral collapse with flaccid paralysis, pulmonary disease and myocardial infarction to be the salient points of reference in the differential diagnosis. Of these, the first three were thought most important, and, in deciding on a single primary disease, he listed the following as possibilities in producing lesions of the posterior pituitary or hypothalamus, mediastinum and vertebral spine: syphilis, brucellosis, tuberculosis, multiple myeloma, metastatic carcinoma and lymphoblastoma or Hodgkin's disease.

Syphilis was thought unlikely because of the prolonged treatment with penicillin. There was little to substantiate a diagnosis of brucellosis and repeated failure to demonstrate tubercle bacilli made tuberculosis a less important con-

sideration. Bone changes were not radiographically consistent with multiple myeloma. Metastatic carcinoma, especially bronchogenic, and lymphoblastoma were stated to be the more likely possibilities and while it was not possible to differentiate the two, a choice of lymphoblastoma, probably Hodgkin's disease, was made.

COMMENT

The symptoms of diabetes insipidus are accounted for by metastatic carcinoma in the posterior pituitary and hypothalamus. Carcinoma of the lung is the most common primary site from which metastasis to the hypophysis cause diabetes insipidus in males.[1] The pathologic compression fractures of vertebrae T-12 and L-1 may have been responsible for the paralysis in the right leg. The spinal canal was markedly reduced in diameter at this level by collapse of vertebrae, a herniated disc and a tumor mass. There was extradural compression of the cord by this tissue. Malnutrition and inanition were due to difficulty in swallowing and to the presence of widespread carcinoma.

The aneurysm of the abdominal aorta may have been the result of syphilis although microscopic sections were not conclusive. The electrographic changes in the absence of myocardial lesions might be explained by vasospastic effects of pitressin® and myocardial ischemia.

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Recent Advances in Research On Rheumatic Fever

The most important item in the treatment of rheumatic fever is concerned with the streptococcus. In most children the first episode of rheumatic fever is a relatively benign affair and the incidence of disabling heart disease after a single attack is very low.

The patients who get into serious trouble are those in whom repeated attacks occur, year after year; these are the individuals who become cardiac cripples. Repeated attacks of rheumatic fever are always the result of repeated streptococcal infections, and if infection can be prevented rheumatic fever can be prevented. This fact is agreed upon by virtually all students of this disease.

Thus we have at hand a therapeutic possibility which is of far greater importance than the salicylates, cortisone, ACTH or anything else that may be applied once rheumatic fever has begun. The disease can be prevented, provided that certain stern conditions are accepted. Any child who has had one attack of rheumatic fever must be regarded as a rheumatic child.—Lewis Thomas, M. D., Minneapolis; *Minnesota Medicine*, 35:1105, December, 1952.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Lethal—This term meaning deadly or fatal comes from the Latin word "lethum" or death and the Greek word "lethe" meaning oblivion or forgetfulness. In the Roman mythology "Lethe" was a river in Hades, the waters of which induced forgetfulness in the souls about to be re-born, so that they would not remember the life they had just left.

Homosexuality—Abnormal sexuality consisting of an attraction towards persons of the same sex. The term applies equally to men and women because the word "homo" as used in this term is not the Latin "homo" meaning man, but the Greek "homo" signifying, the same. Hence the term literally means "the same sex."

Tonsil—The palatine tonsils have been known since the earliest of times and Hippocrates wrote of them. Celsus in the First Century wrote of the tonsils referring to them by the plural term "tonsillae." The Latin word "tonsilla" originally referred to a sharp-pointed stick, which was driven into the ground and used as a mooring pole or hitching stake. Apparently the tonsils projecting out of the throat, bore a fancied resemblance to a mooring stake, projecting out of the ground.

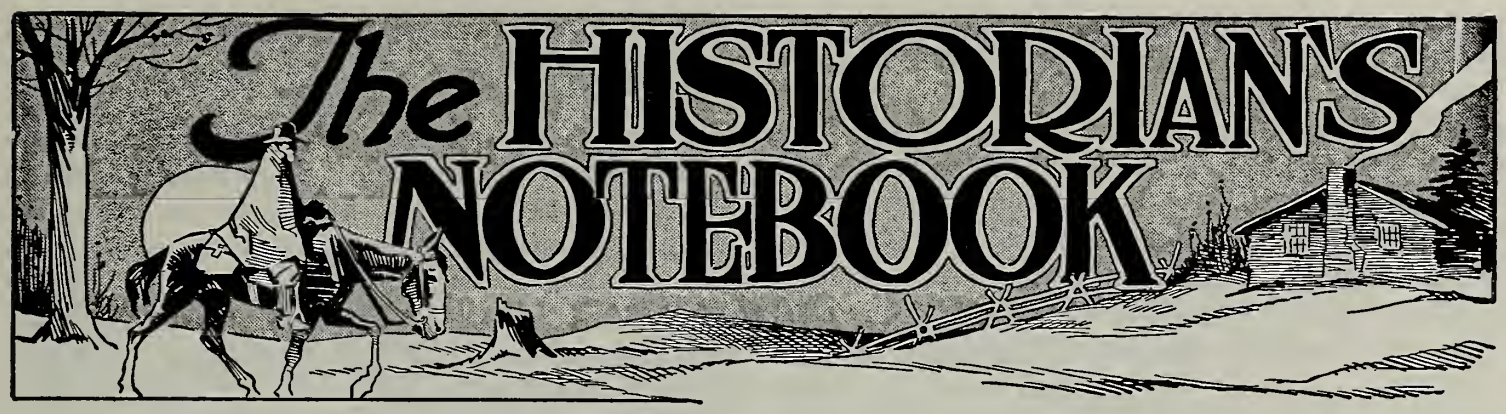
Tongue—A term which is derived from the Anglo-Saxon word "tunge" and which should have been spelled "tung" as is the usual English practice which we see in lung and rung. However, the spelling tongue was brought about by the Norman Conquerers of England in imitation of the French word for tongue which is "langue." The Anglo-Saxon "tunge" comes from the Common Teutonic root "tonga or tunga" and allied are the Swedish and Icelandic words "tunga," the Dutch "tong" and the German "zunge."

Fuller's Earth—This is another name for Kaolin or aluminum silicate. It is a soft unctious clay which was originally used in the process of cleaning or removing grease from cloth, which was called "fulling," and a person who did this kind of work was called a "fuller," hence the term "fuller's earth."

Invalid—An invalid, being a sick or unwell person, is not strong, and this is the literal meaning of this word which is derived from the Latin "in" or not, plus the Latin "validus" or strong.

Tire—Literally meaning to break, tear or wear away. This word is derived from the Anglo-Saxon word "teran" meaning to break, or to tear. It has by extension come to mean "to fatigue or to weary." Thus when you are "tired" and feel exhausted, remember that your strength has literally been torn, worn or broken away.

—Harry Wain, M. D., Mansfield, Ohio.



Doctor William Burnet

VICTOR R. TURNER, M. D.

THE physicians of Ohio may well look back with pride in this, our Sesquicentennial year, upon the glorious career of Dr. William Burnet, founder of our first State Medical Society in America, the New Jersey State Medical Society in 1766, patriot, Surgeon General of the Eastern District of the Continental Army, member of the Continental Congress, friend of Washington, and father of Jacob Burnet of Cincinnati, Ohio, who was the author of the first constitution of the State of Ohio and also father of two other sons, John and George Burnet, who together with John Cumming, settled at Newark, Ohio, in 1802.

Dr. William Burnet was born December 2, 1730. He was graduated from Princeton University in 1749 and studied medicine under the distinguished Dr. Jacob Staats in New York City, as there were no medical schools in America at that time. He established himself in the practice of medicine in Newark, New Jersey, except for the interruption owing to the War of the Revolution. He was a founder of the New Jersey Medical Society in 1766 and was twice president of this body.

In May 1775 Dr. Burnet was made chairman of the Committee of Public Safety; and in the summer of 1776, he dispatched several military companies to the aid of General Washington in the defense of New York City, his eldest son, Dr. William Burnet, Jr., going as surgeon attached to these companies. Later, Dr. William Burnet's private estate was seriously depleted by the British; and his huge medical library, spoken of as the best in the Colonies, was packed in cases and carried to New York by the British.

SURGEON GENERAL OF CONTINENTAL ARMY

In the winter of 1776-77, he was elected a member of the Continental Congress but resigned at the request of General Washington to become Surgeon General of the Eastern District of the Continental Army. He was a member of Washington's official family when the latter was guarding the Hudson, and he was dining with General Benedict Arnold at West Point when the letter came to General Arnold telling him of the capture of Major Andre. Arnold excused himself from the dinner table saying that business of importance was calling him abroad and urged his companions to enjoy themselves until he returned. A little later, Arnold was rowed to the British ship *Vulture*, some distance below West Point, a traitor to his country. In 1780 and 1781 Dr. Burnet was elected again to the Continental Congress. After the war he returned to his practice in Newark, New Jersey.

Submitted December 10, 1952.

The Author

● **Dr. Turner, Newark, Ohio, now retired, was formerly roentgenologist and radiologist at the Newark City Hospital.**

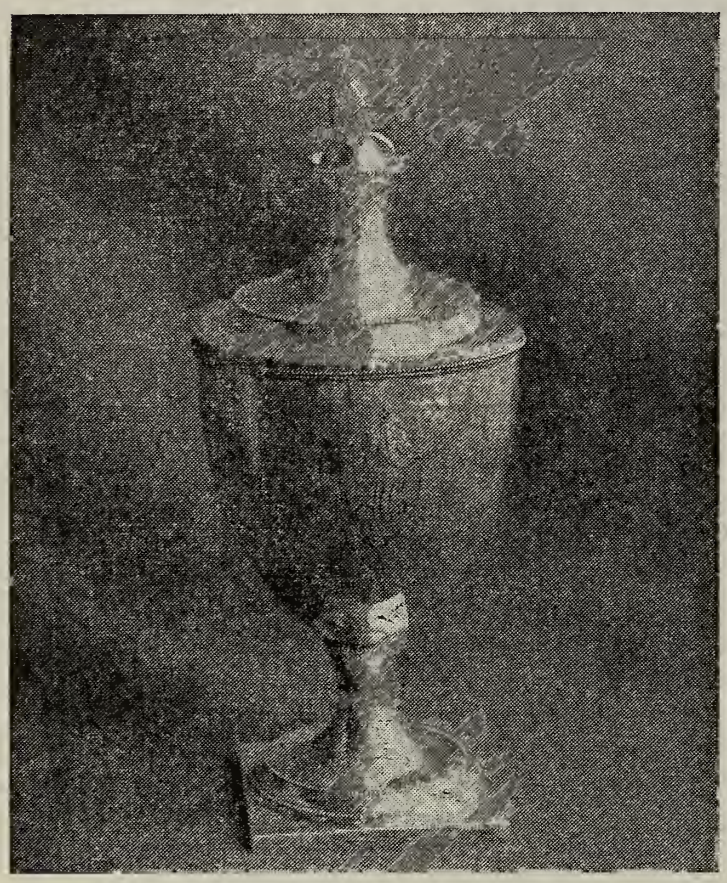
DESCENDANTS

Dr. Burnet married Mary Camp, the daughter of Nathaniel Camp of Newark, by whom he had eleven children. Dr. William Burnet, Jr., was a military surgeon. His twin brother Ichabod was a major and aide-de-camp to Major General Nathaniel Green. Jacob was one of the early settlers of Cincinnati, Ohio, and became an eminent judge and senator from Ohio. Hannah married Captain Abraham Kinney; her painting by the celebrated Rembrandt Peale hangs in the Metropolitan Museum. Her son was the distinguished minister to Italy and later editor of the *Newark Daily Advertizer*; Elizabeth married Daniel Thew. It was in their home that Alexander Hamilton was taken after he was fatally wounded in his duel with Aaron Burr at Weehawken. Elizabeth Thew's daughter, Caroline, married Nathaniel Wright. They settled in Cincinnati after Mr. Wright graduated in law at Harvard University.

Dr. William Burnet's second wife was Gertrude

Gouverneur by whom he had three sons, the youngest of whom, David Gouverneur Burnet, was the first provincial president of Texas in 1836 before it was a state. Later he was elected senator from Texas after the Civil War but was not admitted to a seat, as the state had not been reconstructed.

Dr. William Burnet belonged to the Distinguished Society of the Cincinnatus, an organization of the officers, following the Revolution. His diploma, signed by General Washington, is now in the possession of Mr. Jacob Burnet, of Lenoir, North Carolina. General Washington presented a silver service to Dr. Burnet and his family



Sugar Bowl, part of silver service presented to Dr. William Burnet by General George Washington, after the Revolutionary War.

after the war, and some of this is still in the possession of his descendants. Mrs. Edwin Besuden, of Newark, Ohio, great great granddaughter of Dr. William Burnet, is the proud possessor of the sugar bowl which was part of this silver service. It was on exhibition at the Sesquicentennial Exposition of Newark, Ohio, in 1952.

Before sailing back to France, young General Lafayette presented his friend with a brace of dueling pistols. Dr. Burnet died October 7, 1791.

Of the greatest importance to the early history of Ohio was the arrival at Cincinnati, Ohio, in the spring of 1796, of Dr. William Burnet's son, Jacob Burnet. Jacob was the author of the early Constitution of Ohio. He had graduated from Princeton and had studied law for four and one-half years under Judge Boudinot, a distinguished jurist, and had been admitted to the bar by the Supreme Court of New Jersey.

When Jacob Burnet arrived in Cincinnati with his brother George, who was also an attorney, they found that Cincinnati numbered about 500 inhabitants including the military personnel of Fort Washington. The buildings were log cabins, and there was a large pond filled with alder bushes at the corner of Main and Fifth Streets. There were just seven other attorneys in the town besides themselves. They took up lodging at Mr. Yeatmans, the principal hotel, and there formed a close friendship with Arthur St. Clair, the first governor of the Northwest Territory, who also lived at the hotel, and who, by the way, had studied medicine.

SON IS EMINENT JURIST

In 1799 John Adams appointed Jacob Burnet to the legislative council of the Northwest Territory which seat he retained until 1803. In 1799 alone he drafted sixteen bills and was appointed to prepare and report rules and regulations for conducting the business of the legislative council, also an answer to the Governor's address, and finally an address made to the president of the United States. Later he became the author of the first constitution of the State of Ohio. At the meetings he worked with Meigs, Tiffin, Huntington, and Worthington, later to become governors of the state, and also William Henry Harrison, who became the ninth president of the United States. It was not long before Jacob Burnet became an eminent judge. He traveled widely through the swamps to Marietta, Athens, Chillicothe, and even as far north as Detroit, where he attended court every year until 1802. These jaunts were attended with great exposure, fatigue, and hazard.

Following the war of 1812, there was a terrible financial depression in the Northwest. Banks failed, money was not to be had on any terms, and settlers with their lands mortgaged could not pay their interest. Judge Burnet formulated a plan which was enacted by the United States Congress in 1821; as a result of which, the people of the Northwest were relieved, confidence in the government was restored, and the disquietude and distress of the western country was alleviated.

From 1812 to 1816, Judge Burnet was a member of the Ohio State Legislature, and in 1812 he was appointed Judge of the Ohio Supreme Court which position he held until 1828 when he was appointed to the United States Senate. While in the Senate, he did much for the people of Ohio, especially in the way of Federal aid for the construction of the Canal System. As a humanitarian act, he made an appeal to the United States Senate for a pension to be given to the famous Simon Kenton, whose services and suffering for his country were well known. The bill was passed by a large majority. In 1840 at the Harrisburg Convention, Senator Burnet succeeded in throwing the presidential nomination to his friend and fellow Ohioan, William Henry

Harrison. After his service in Congress was ended Senator Burnet retired to his old-styled mansion at the corner of Seventh and Eleventh Streets, Cincinnati, Ohio, where he spent his declining years among old friends. He died in 1853.

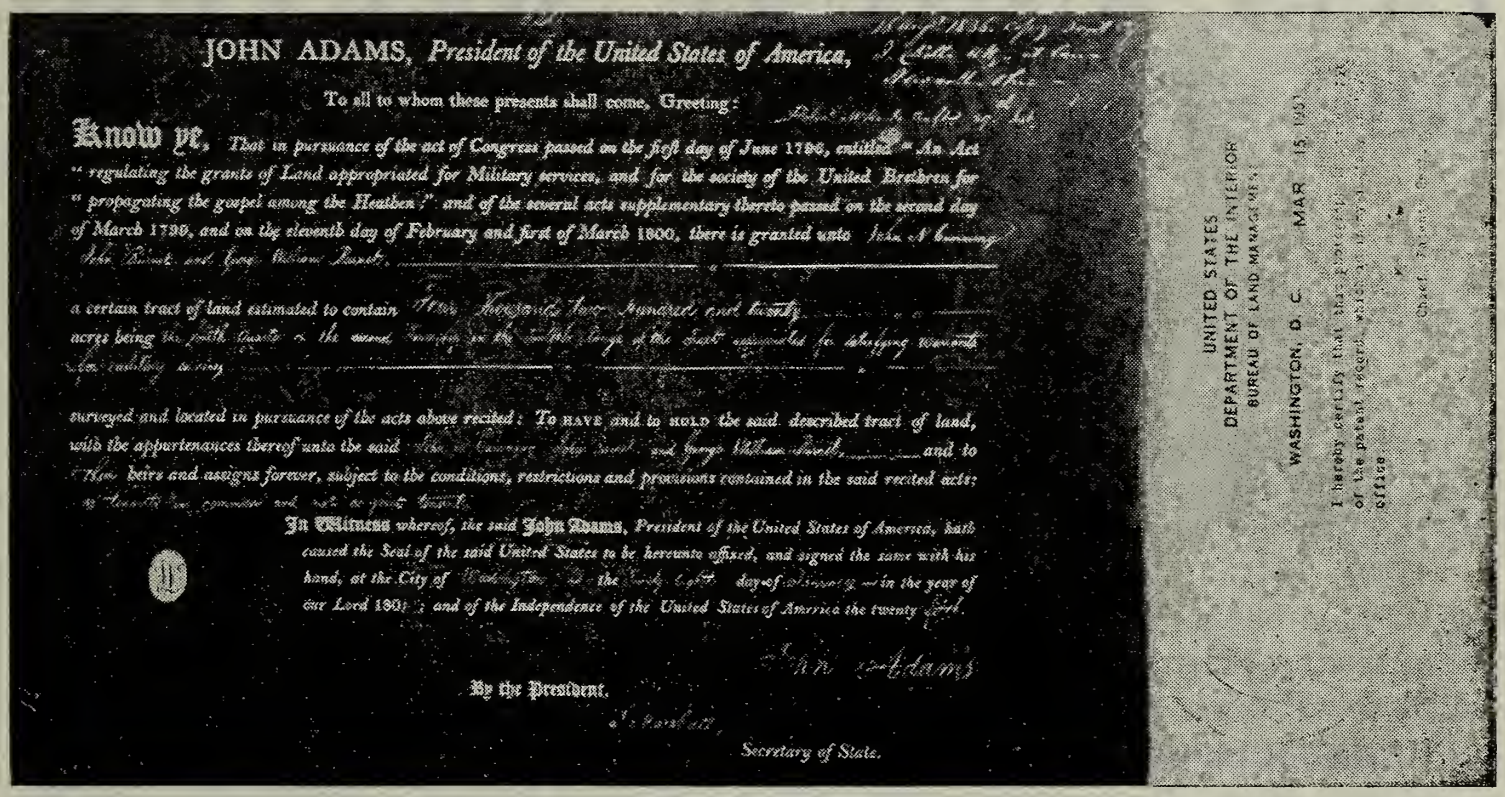
FOUNDING OF NEWARK, OHIO

Two other sons of Dr. William Burnet, John and George W. Burnet, together with a friend, John Cumming, were instrumental in establishing the settlement of Newark, Ohio. According to the laws governing the Northwest Territory at that time, a settlement had to be made in tracts of 4,000 acres or more. So the Burnets and Cumming bought in United States Military Bounty Warrants of one-hundred-acre tracts from about forty different Revolutionary soldiers, or of Newark, New Jersey, from 1789 to 1803, died in 1813.

In closing, I feel that the physicians of Ohio and of the nation might well be proud of the name of Dr. William Burnet, who did so much to help save our country in its darkest hour, and whose sons carried on the good work and did so much for the early settlement of our great State of Ohio at its beginning 150 years ago.

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18. Burnet, William: Columbia Encyclopedia. New York, N. Y., Columbia Un. Press, 1940.



JOHN ADAMS, *President of the United States of America,*

To all to whom these presents shall come, Greeting:

KNOW YE, That in pursuance of the act of Congress passed on the fifth day of June 1796, entitled "An Act regulating the grants of Land appropriated for Military services, and for the society of the United Brethren for propagating the gospel among the Heathen;" and of the several acts supplementary thereto passed on the second day of March 1799, and on the eleventh day of February and first of March 1800, there is granted unto John Cumming, John Burnet and [illegible] Burnet,

a certain tract of land estimated to contain Four Thousand Two Hundred and Twenty acres being the fourth quarter of the second township on the [illegible] range of the tract appointed for satisfying warrants for military service

surveyed and located in pursuance of the acts above recited: To HAVE and to HOLD the said described tract of land, with the appurtenances thereof unto the said John Cumming, John Burnet and George William Burnet, and to their heirs and assigns forever, subject to the conditions, restrictions and provisions contained in the said recited acts: In Testimony whereof, the said John Adams, President of the United States of America, hath caused the Seal of the said United States to be hereunto affixed, and signed the same with his hand, at the City of Washington the twenty eighth day of January in the year of our Lord 1801, and of the Independence of the United States of America the twenty fifth.

John Adams

By the President.

[illegible]

Secretary of State.

UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. MAR 15 1951

I hereby certify that the [illegible] is a true and complete copy of the patent record, which is on file in this office.

Chief [illegible] Office

Land Grant issued to John Cumming, John Burnet and George W. Burnet and signed by President John Adams, permitting the settlement of Newark, Ohio, in 1802.

their heirs or assigns, and thus made enough (4,220 acres) to permit them to establish a settlement. John Burnet was entitled to 2,100 acres; John Cumming, to 1,620 acres; and George W. Burnet, to 500 acres. A photostatic copy of the Army Land Grant of 4,220 acres, signed by President John Adams on the 28th day of January, in the year of our Lord, 1801, and now in possession of the Licking County Historical Society is reproduced on this page.

Newark, Ohio, was laid out at the forks of the Licking River according to the plan of Newark, New Jersey, from whence the Burnets and Cumming came. William C. Schenck, a friend, came over from Warren County to survey the land and ascertain its location and also to act as agent for the Burnets and Cumming. Unfortunately, George W. Burnet died of tuberculosis in 1801. John Burnet, who was postmaster



ANNOUNCING

Official Program for the

1953 ANNUAL MEETING
OHIO STATE MEDICAL ASSOCIATION
CINCINNATI

April 21, 22 and 23, 1953

HERE are details that Ohio doctors have been waiting for—the complete program of the 1953 Annual Meeting, Ohio State Medical Association—topics to be discussed, names of speakers and discussants, and other pertinent information.

TIME AND PLACE: Tuesday, Wednesday and Thursday, April 21, 22 and 23. Registration begins at 8:00 a. m. on Tuesday; last clinical session ends at 12:45 p. m. on Thursday. Scientific sessions will be held in the Netherland Plaza, Sheraton-Gibson and Sinton Hotels; exhibits in the Netherland Plaza.

REGISTRATION: Registration Headquarters will be in the Fourth Floor Foyer of the Netherland Plaza Hotel—open from 8 a. m. to 6 p. m. on Tuesday and Wednesday and from 8 a. m. to 12:45 p. m. on Thursday. There is no registration charge. Admission to all sessions and to the exhibits will be by badge secured at Registration Headquarters. Those eligible to register are: Members of the Ohio State Medical Association (who should have 1953 Membership Cards for presentation at time of registration); physicians from other states who are members of their respective state medical societies; residents, interns, medical students, nurses, health workers, and others who are presented at Registration Headquarters by members. The Woman's Auxiliary will provide registration facilities for its members and others who are eligible for membership, at its hotel headquarters.



MOTION PICTURES: An innovation of this year's program will be the presentation of medical motion pictures. These movies will be the pick of available pictures which are fast becoming an integral part of present-day medical education. There will be a commentator, who will be an authority on the subject under discussion, for

each movie. These movie programs will be presented each morning from 8:30 to 9:15 o'clock.

GENERAL SESSIONS: More emphasis is being placed this year on these sessions which will feature outstanding speakers. Topics for discussion have been picked to help physicians in their everyday practice. Clinicians who are authorities in their respective fields have been chosen to present subjects to the interest of physicians in every branch of practice.

SPECIALTY SECTION PROGRAMS: Programs are being presented by eight specialty sections—Sections on Anesthesiology; Obstetrics and Gynecology; Urology; Ophthalmology; Otology, Rhinology and Laryngology; Pediatrics; Radiology; and General Practice. The Section on Anesthesiology and the Section on Obstetrics and Gynecology will hold a joint session and separate sessions. All physicians, regardless of whether or not they belong to the specialty, are welcome to attend these sessions.



OUT-OF-STATE GUEST SPEAKERS: Included on the program are 13 nationally known guest speakers from other states—each an authority in his field. Several of these speakers will talk at specialty section meetings and at general sessions.

HOUSE OF DELEGATES: The policy-making body of the Association will meet twice during the Annual Meeting. The first meeting will be held on Tuesday, April 21, in the Restaurant Continental, Netherland Plaza Hotel, beginning at 4:00 p. m. The second meetting will be on Thursday in Parlors A-D, Netherland Plaza, beginning with a luncheon at 1:00 p. m. Any member of the Association is welcome to attend the business sessions. However, the dinner and luncheon are reserved for delegates and others attending in an official capacity.

SCIENTIFIC EXHIBITS: Latest developments in medical research and investigation will be emphasized in these features. Visitors will have an opportunity to discuss with sponsors of exhibits the materials displayed. Ample recess periods throughout the program will give members time to tour the exhibits. Scientific Exhibits will be in the South Hall, Fourth Floor, Netherland Plaza.

TECHNICAL EXHIBITS: These commercial displays form an important educational feature of the Annual Meeting. Here will be found the latest developments in pharmaceutical products, surgical instruments, therapeutic equipment and other needs of the profession. Technical Exhibits will be in the Hall of Mirrors, Third Floor and North Hall, Fourth Floor, Netherland Plaza Hotel.



WOMAN'S AUXILIARY: The Woman's Auxiliary to the Ohio State Medical Association will hold its annual meeting concurrently with that of the Association. Sessions will be in the Sheraton-Gibson Hotel.

ANNUAL BANQUET: Wednesday evening is reserved for the feature social function of the Annual Meeting—the Annual Banquet scheduled in the Pavillon Caprice, Netherland Plaza Hotel. The banquet will be followed by an evening of entertainment and dancing. A charge of $6.50 per person will be made. Instruction as to how reservations may be made in advance of the meeting will be contained in a special folder to be mailed to members.

1953 ANNUAL MEETING

Ohio State Medical Association

Netherland Plaza Hotel, Hotel Sinton and Sheraton-Gibson Hotel, Cincinnati

TUESDAY, APRIL 21

TIME	EVENT	PLACE
8:00 A. M.	**REGISTRATION OPENS**	Fourth Floor Foyer Netherland Plaza Hotel
8:30 to 9:15 A. M.	**MEDICAL MOTION PICTURES**	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
9:30 to 10:30 A. M.	**GENERAL SESSION** ROBERT D. DRIPPS, M. D. Philadelphia, Pa. JOHN K. LATTIMER, M. D. New York, N. Y.	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
10:30 to 11:15 A. M.	**INTERMISSION TO TOUR THE EXHIBITS**	Hall of Mirrors, Third Floor (Technical) North Hall, Fourth Floor (Technical) South Hall, Fourth Floor (Scientific) Netherland Plaza Hotel
11:15 A. M. to 12:15 P. M.	**GENERAL SESSION** RALPH A. REIS, M. D. Chicago, Ill. FRANK D. COSTENBADER, M. D. Washington, D. C.	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
12:15 to 2:00 P. M.	**RECESS FOR LUNCHEON AND TOUR OF EXHIBITS**	
2:00 to 3:00 P. M.	**SECTION ON ANESTHESIOLOGY** and **SECTION ON OBSTETRICS AND GYNECOLOGY** *(Combined Session)*	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
2:00 to 4:30 P. M.	**SECTION ON OPHTHALMOLOGY**	Rookwood Room, Lobby Floor Hotel Sinton
2:00 to 4:00 P. M.	**SECTION ON UROLOGY**	Ballroom, Lobby Floor Hotel Sinton
3:00 to 4:30 P. M.	**SECTION ON ANESTHESIOLOGY**	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
3:00 to 4:30 P. M.	**SECTION ON OBSTETRICS AND GYNECOLOGY**	Parlors A, B, C, D, Fourth Floor Netherland Plaza Hotel
4:30 to 6:00 P. M.	**TOUR OF THE EXHIBITS**	
4:00 to 6:00 P. M.	**HOUSE OF DELEGATES**	Restaurant Continental, Lobby Floor Netherland Plaza Hotel

1953 ANNUAL MEETING

Ohio State Medical Association

Netherland Plaza Hotel, Hotel Sinton and Sheraton-Gibson Hotel, Cincinnati

WEDNESDAY, APRIL 22

TIME	EVENT	PLACE
8:00 A. M.	**REGISTRATION**	Fourth Floor Foyer Netherland Plaza Hotel
8:30 to 9:15 A. M.	**MEDICAL MOTION PICTURES**	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
9:30 to 10:30 A. M.	**GENERAL SESSION** CHEVALIER L. JACKSON, M. D. Philadelphia, Pa. GEORGE M. WHEATLEY, M. D. New York, N. Y.	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
10:30 to 11:15 A. M.	**INTERMISSION TO TOUR THE EXHIBITS**	Hall of Mirrors, Third Floor (Technical) North Hall, Fourth Floor (Technical) South Hall, Fourth Floor (Scientific) Netherland Plaza Hotel
11:15 A. M. to 12:15 P. M.	**GENERAL SESSION** RICHARD H. CHAMBERLAIN, M. D. Philadelphia, Pa. ANDREW S. TOMB, M. D. Victoria, Texas	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
12:15 to 2:00 P. M.	**RECESS FOR LUNCHEON AND TOUR OF EXHIBITS**	
2:00 to 4:00 P. M.	**SECTION ON OTOLOGY, RHINOLOGY AND LARYNGOLOGY**	Parlors A, B, C, D, Fourth Floor Netherland Plaza Hotel
2:00 to 4:00 P. M.	**SECTION ON PEDIATRICS**	Ballroom, Lobby Floor Hotel Sinton
2:00 to 4:10 P. M.	**SECTION ON RADIOLOGY**	Roof Garden Sheraton-Gibson Hotel
2:00 to 4:10 P. M.	**SECTION ON GENERAL PRACTICE**	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
4:10 to 6:00 P. M.	**TOUR OF THE EXHIBITS**	
7:30 P. M.	**ANNUAL BANQUET**	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel

1953 ANNUAL MEETING

Ohio State Medical Association

Netherland Plaza Hotel, Hotel Sinton and Sheraton-Gibson Hotel, Cincinnati

THURSDAY, APRIL 23

TIME	EVENT	PLACE
8:00 A. M.	**REGISTRATION**	Fourth Floor Foyer Netherland Plaza Hotel
8:30 to 9:15 A. M.	**MEDICAL MOTION PICTURES**	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
9:30 to 10:30 A. M.	**GENERAL SESSION** JOSEPH B. KIRSNER, M. D. Chicago, Ill. LESTER R. DRAGSTEDT, M. D. Chicago, Ill.	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
10:30 to 11:15 A. M.	**INTERMISSION TO TOUR THE EXHIBITS**	Hall of Mirrors, Third Floor (Technical) North Hall, Fourth Floor (Technical) South Hall, Fourth Floor (Scientific) Netherland Plaza Hotel
11:15 A. M. to 12:45 P. M.	**GENERAL SESSION** CHARLES K. FRIEDBERG, M. D. New York, N. Y. LOUIS M. ROUSSELOT, M. D. New York, N. Y.	Pavillon Caprice, Fourth Floor Netherland Plaza Hotel
1:00 P. M.	**HOUSE OF DELEGATES**	Parlors A, B, C, D, Fourth Floor Netherland Plaza Hotel
1:00 to 3:00 P. M.	**EXHIBITS OPEN UNTIL 3:00 P. M.**	Hall of Mirrors, Third Floor (Technical) North Hall, Fourth Floor (Technical) South Hall, Fourth Floor (Scientific) Netherland Plaza Hotel

RESOLUTIONS TO BE PRESENTED AT 1953 MEETING SHOULD BE SENT TO COLUMBUS FOR PUBLICATION IN JOURNAL

County Medical Societies which plan to have their delegates introduce resolutions at the 1953 Annual Meeting of the Ohio State Medical Association, April 21-23, Cincinnati, or individual delegates who have prepared resolutions for consideration at the Cincinnati meeting, should, if possible, submit copies of such resolutions to the Columbus Office so they can be published in the April issue of *The Journal.*

Copies of such resolutions should be sent to the Columbus Office on or before March 20 to insure publication in the April *Journal.*

In 1948 the House of Delegates adopted a resolution requesting that this action be taken by County Medical Societies and individual delegates.

It was pointed out in the 1948 action that this would give delegates an opportunity to know in advance the subjects to be considered through resolutions and a chance to discuss such matters with their local societies and receive instructions on matters of policy involved.

TUESDAY, APRIL 21

8:00 A. M.

REGISTRATION OPENS

Fourth Floor Foyer
Netherland Plaza Hotel

TUESDAY, APRIL 21

8:30 A. M. to 9:15 A. M.

MEDICAL MOTION PICTURES

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: Donald B. Effler, M. D., Cleveland, Chairman, Committee on Motion Pictures.

ANEMIA

William Dameshek, M. D., Boston, Mass., Professor of Clinic Medicine and Director of Blood Research Laboratories, Tufts College Medical School.

Commentator: Richard W. Vilter, M. D., Cincinnati.

MYASTHENIA GRAVIS

Donald B. Effler, M. D., and Kenneth L. Allen, M. D., Cleveland, Department of Thoracic Surgery, Cleveland Clinic.

Commentator: Dr. Effler.

TUESDAY, APRIL 21

9:30 A. M.

GENERAL SESSION

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: A. Carlton Ernstene, M. D., Cleveland, Chairman, Committee on Scientific Work.

9:30 to 10:00

THE ANESTHETIC MANAGEMENT OF PATIENTS WITH HEART DISEASE

Robert D. Dripps, M. D., Philadelphia, Pa., Professor of Anesthesiology, University of Pennsylvania School of Medicine.

10:00 to 10:30

TREATMENT OF RENAL TUBERCULOSIS WITH ISONICOTINIC ACID HYDRAZID, STREPTOMYCIN AND PAS

John K. Lattimer, M. D., New York, N. Y., Assistant Professor of Urology, Columbia University College of Physicians and Surgeons.

10:30 to 11:15

INTERMISSION TO TOUR EXHIBITS

TUESDAY, APRIL 21

11:15 A. M.

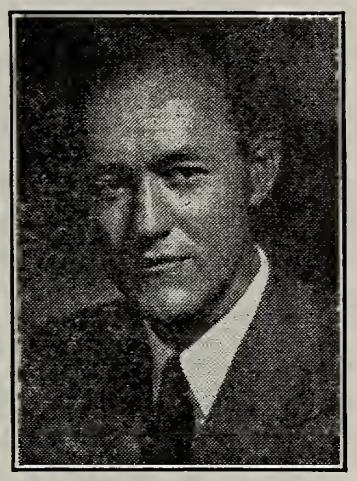
GENERAL SESSION

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

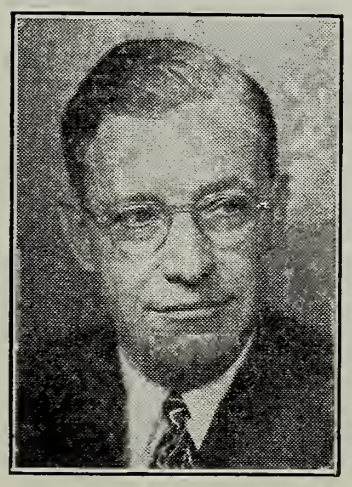
Presiding: Paul A. Davis, M. D., Akron, President-Elect, Ohio State Medical Association.



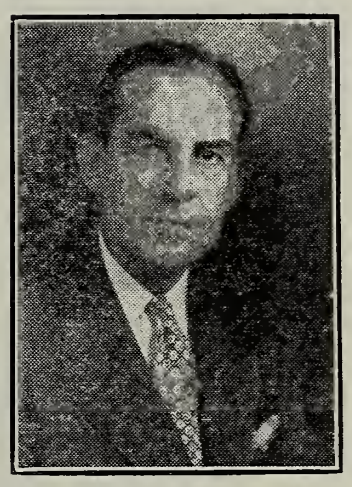
ROBT. D. DRIPPS, M. D.
Philadelphia



JOHN K. LATTIMER, M.D.
New York



RALPH A. REIS, M. D.
Chicago



F. D. COSTENBADER, M.D.
Washington, D. C.

11:15 to 11:45

A REEVALUATION OF ENDOCRINE THERAPY IN OBSTETRICS AND GYNECOLOGY

Ralph A. Reis, M. D., Chicago, Ill., Professor of Obstetrics and Gynecology, Northwestern University Medical School.

11:45 to 12:15

WHAT TO DO ABOUT STRABISMUS

Frank D. Costenbader, M. D., Washington, D. C., Surgeon (ophthalmology), Episcopal Eye, Ear and Throat Hospital and Children's Hospital.

12:15 to 2:00

RECESS FOR LUNCHEON AND TOUR OF EXHIBITS

TUESDAY, APRIL 21

2:00 P. M.

JOINT SESSION OF SECTION ON ANESTHESIOLOGY AND SECTION ON OBSTETRICS AND GYNECOLOGY

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: A. L. Schwartz, M. D., Cincinnati, Chairman, Section on Anesthesiology.

WOMAN'S AUXILIARY MEETING PROGRAM

Complete program for the Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association, which will be held in Cincinnati at the Hotel Sheraton-Gibson, April 21, 22 and 23, will be published in the March issue of the *Ohio Medical Auxiliary News*. This will be mailed to all auxiliary members about March 15.

That issue of the *Auxiliary News* will carry a reservation blank for the luncheons on Tuesday and Wednesday, April 21 and 22.

The Nominating Committee, which will report at the Cincinnati meeting, met on Thursday, January 22, in Columbus with Mrs. W. R. Gibson as chairman. All 11 districts were represented.

PANEL ON ANALGESIA AND ANESTHESIA IN OBSTETRICS

2:00 to 2:10

PSYCHOLOGIC PREPARATION FOR LABOR

J. J. Brumbaugh, M. D., Canton.

2:10 to 2:20

ANALGESIC MANAGEMENT OF LABOR

Norman E. Wentsler, M. D., Akron.

2:20 to 2:30

SAFETY FACTORS IN INHALATION ANESTHESIA FOR OBSTETRICS

A. William Friend, M. D., Akron.

2:30 to 2:40

SOME CONSIDERATIONS OF REGIONAL AND NERVE BLOCK ANESTHESIA IN OBSTETRICS

Jay Jacoby, M. D., Columbus.

2:40 to 3:00

QUESTION AND ANSWER PERIOD.

Note: At 3:00 P. M. the joint session will dissolve and each section will then hold a one-hour meeting of its own.

TUESDAY, APRIL 21

2:00 P. M.

SECTION ON OPHTHALMOLOGY

Rookwood Room, Lobby Floor
Hotel Sinton

Thayer L. Parry, M. D., Akron.....Chairman
Ralph H. Miller, M. D., Cincinnati.....Secretary

2:00 to 2:10

Business Session. Report of Nominating Committee. Election of Officers.

2:10 to 2:30

INFLUENCE OF VERTICAL DEVIATION ON HORIZONTAL TROPIAS

George T. Stine, M. D., Columbus.

2:30 to 3:10

THE SURGERY OF STRABISMUS — UNILATERAL OR BILATERAL

Frank D. Costenbader, M. D., Washington, D. C., Surgeon (ophthalmology), Episcopal Eye, Ear and Throat Hospital and Children's Hospital.

3:10 to 3:30

PANEL DISCUSSION: STRABISMUS

Dr. Costenbader and Dr. Stine.

3:30 to 3:40

WIDE ANGLE GLAUCOMA

H. Herbert Insel, M. D., Dayton.

3:40 to 4:00

END RESULTS IN RETINAL DETACHMENT SURGERY

R. J. Kennedy, M. D., Cleveland.

4:00 to 4:30

QUESTION AND ANSWER PERIOD.

4:30 to 6:00

TOUR OF EXHIBITS

TUESDAY, APRIL 21

2:00 P. M.

SECTION ON UROLOGY

Ballroom, Lobby Floor
Hotel Sinton

T. Brent Wayman, M. D., Cincinnati.....Chairman
Edward F. Ockuly, M. D., Toledo.....Secretary

2:00 to 2:10

Business Meeting. Report of Nominating Committee. Election of Officers.

2:10 to 2:50

CURRENT THERAPY FOR GENITOURINARY TUBERCULOSIS

John K. Lattimer, M. D., New York, N. Y., Assistant Professor of Urology, Columbia University College of Physicians and Surgeons.

2:50 to 3:10

THE SIGNIFICANCE OF PYURIA IN CHILDREN

Frank B. Bicknell, M. D., Detroit, Mich., Associate Professor of Urology, Wayne University College of Medicine.

3:10 to 3:30

THE UROLOGICAL MASQUERADE

Victor C. Laughlin, M. D., Cleveland.

3:30 to 4:00

QUESTION AND ANSWER PERIOD.

4:00 to 6:00

TOUR OF EXHIBITS

TUESDAY, APRIL 21

3:00 P. M.

SECTION ON ANESTHESIOLOGY

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

(See pages 235-236 for combined session of this section and Section on Obstetrics and Gynecology at 2:00 P. M.)

A. L. Schwartz, M. D., Cincinnati.....Chairman
B. B. Sankey, M. D., Cleveland.....Secretary

3:05 to 3:30

CAUSE AND TREATMENT OF PROLONGED DEPRESSION FROM VARIOUS CURARE DRUGS

Robert D. Dripps, M. D., Philadelphia, Pa., Professor of Anesthesiology, University of Pennsylvania School of Medicine.

3:30 to 3:40

Business Session. Report of Nominating Committee. Election of Officers.

3:40 to 3:50

IMPORTANT FACTORS IN THE STERILIZATION OF ANESTHETIC EQUIPMENT

Carolyn H. Ziegler, M. D., Columbus.

3:50 to 4:00

TRACHEOTOMY AS AN AID TO THE ANESTHESIOLOGIST

Max Krakauer, M. D., Cincinnati.

4:00 to 4:30

QUESTION AND ANSWER PERIOD.

4:30 to 6:00

TOUR OF EXHIBITS

Obstetricians and Gynecologists To Meet With Cincinnati Group

The Cincinnati Obstetrical Society is sponsoring for the ob. and gyn. members of the Ohio State Medical Association, a get-together for cocktails, dinner and entertainment, following the meeting of the Section on Obstetrics and Gynecology.

Cocktails are to be served on Tuesday, April 21, at 6:00 p. m., in Parlors A, B, C and D of the Netherland Plaza Hotel, dinner and entertainment to follow. Besides Cocktails and a fillet mignon dinner, a unique form of entertainment has been arranged.

Those who plan to attend are requested to send reservation and check in the amount of $8.00 to: Dr. Stanley T. Garber, 104 William Howard Taft Road, Cincinnati 19.

TUESDAY, APRIL 21

3:00 P. M.

SECTION ON OBSTETRICS AND GYNECOLOGY

Parlors A, B, C, D, Fourth Floor
Netherland Plaza Hotel

(See pages 235-236 for combined session of this section and Section on Anesthesiology at 2:00 P. M.)

Ralph K. Ramsayer, M. D., Canton.....Chairman
Arthur G. King, M. D., Cincinnati.....Secretary

3:00 to 4:00

SEX HORMONE THERAPY IN GYNECOLOGY

Round-table discussion of this subject. Following two 10-minute presentations by Ralph A. Reis, M. D., Chicago, Ill., Professor of Obstetrics and Gynecology, Northwestern University Medical School, and Eduard Eichner, M. D., Cleveland, there will be general discussion and questions and answers in which those in attendance are urged to participate.

4:00 to 4:10

Business Session. Report of Nominating Committee. Election of Officers.

4:10 to 4:30

QUESTION AND ANSWER PERIOD.

4:30 to 6:00

TOUR OF EXHIBITS

4:00 to 6:00

HOUSE OF DELEGATES

BUSINESS SESSION TO BE FOLLOWED BY DINNER

Restaurant Continental, Lobby Floor
Netherland Plaza Hotel

WEDNESDAY, APRIL 22
8:00 A. M.
REGISTRATION
Fourth Floor Foyer
Netherland Plaza Hotel

WEDNESDAY, APRIL 22
8:30 A. M. to 9:15 A. M.
MEDICAL MOTION PICTURES
Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: Donald B. Effler, M. D., Cleveland, Chairman, Committee on Motion Pictures.

BRONCHOGENIC CARCINOMA

Brian B. Blades, M. D., Washington, D. C., Professor of Surgery, George Washington Medical School.
Commentator: Donald B. Effler, M. D., Cleveland.

REHABILITATION FOLLOWING ILEOSTOMY

Rupert B. Turnbull, Jr., M. D., Cleveland, Department of General Surgery, Cleveland Clinic.
Commentator: Dr. Turnbull.

WEDNESDAY, APRIL 22
9:30 A. M.
GENERAL SESSION
Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: H. M. Clodfelter, M. D., Columbus, President, Ohio State Medical Association.

9:30 to 10:00
BRONCHOSCOPY IN RELATION TO THORACIC SURGERY

Chevalier L. Jackson, M. D., Philadelphia, Pa., Professor, Department of Laryngology and Bronchoesophagology, Temple University School of Medicine.

10:00 to 10:30
THE PROPHYLAXIS OF ACCIDENTAL TRAUMA

George M. Wheatley, M. D., New York, N. Y., Chairman, Accident Prevention Committee, American Academy of Pediatrics.

10:30 to 11:15
INTERMISSION TO TOUR EXHIBITS

WEDNESDAY, APRIL 22
11:15 A. M.
GENERAL SESSION
Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: Thomas E. Rardin, M. D., Columbus, Member, Committee on Scientific Work.

11:15 to 11:45
RADIATION HAZARDS IN DIAGNOSTIC ROENTGENOLOGY

Richard H. Chamberlain, M. D., Philadelphia, Pa., Professor of Radiology, University of Pennsylvania School of Medicine.



C. L. JACKSON, M. D.
Philadelphia



GEO. M. WHEATLEY, M.D.
New York



ANDREW S. TOMB, M.D.
Victoria, Texas



R. H. CHAMBERLAIN, M.D.
Philadelphia

11:45 to 12:15
THE PROBLEM DRINKER—A MEDICAL RESPONSIBILITY

Andrew S. Tomb, M. D., Victoria, Texas, Past-President, Texas Academy of General Practice.

12:15 to 2:00
RECESS FOR LUNCHEON AND TOUR OF EXHIBITS

WEDNESDAY, APRIL 22
2:00 P. M.
SECTION ON OTOLOGY, RHINOLOGY AND LARYNGOLOGY
Parlors A, B, C, D, Fourth Floor
Netherland Plaza Hotel

S. C. Yinger, M. D., Springfield.....Chairman
Clyde G. Chamberlin, M. D., Hamilton.....Secretary

2:00 to 2:20
TUMORS AND CYSTS OF THE FACE

Paul M. Moore, Jr., M. D., Cleveland.

2:20 to 2:45
HEADACHE AS SEEN BY THE OTOLARYNGOLOGIST

Raymond L. Hilsinger, M. D., Cincinnati.

2:45 to 3:15

CURRENT TRENDS IN TREATMENT OF CANCER OF THE LARYNX

Chevalier L. Jackson, M. D., Philadelphia, Pa., Professor of Laryngology and Bronchoesophagology, Temple University School of Medicine.

3:15 to 3:45

QUESTION AND ANSWER PERIOD.

3:45 to 4:00

Business Session. Report of Nominating Committee. Election of Officers.

4:00 to 6:00

TOUR OF EXHIBITS

WEDNESDAY, APRIL 22

2:00 P. M.

SECTION ON PEDIATRICS

Ballroom, Lobby Floor
Hotel Sinton

Robert B. Hauver, M. D., Cleveland ..... Chairman
Robert H. Kotte, M. D., Cincinnati ..... Secretary

2:00 to 2:30

THE CHILD ACCIDENT PROBLEM

George M. Wheatley, M. D., New York, N. Y., Chairman, Accident Prevention Committee, American Academy of Pediatrics.

2:30 to 3:00

GAMMA GLOBULIN IN THE PROPHYLAXIS OF POLIOMYELITIS

Albert B. Sabin, M. D., and A. A. Weech, M. D., Cincinnati.

3:00 to 3:30

ETIOLOGY OF CONGENITAL MALFORMATIONS

Josef Warkany, M. D., Cincinnati.

3:30 to 3:50

QUESTION AND ANSWER PERIOD.

3:50 to 4:00

Business Session. Report of Nominating Committee. Election of Officers.

4:00 to 6:00

TOUR OF EXHIBITS

WEDNESDAY, APRIL 22

2:00 P. M.

SECTION ON RADIOLOGY

Roof Garden
Sheraton-Gibson Hotel

Harold G. Reineke, M. D., Cincinnati ..... Chairman
Benjamin Felson, M. D., Cincinnati ..... Secretary

2:00 to 2:15

CANCER OF THE SKIN

Charles M. Barrett, M. D., Cincinnati.

Ohio Chest Physicians To Hold Program

The Annual Meeting of the Ohio Chapter of the American College of Chest Physicians will be held at the Hotel Sheraton-Gibson, Parlor "E", on Wednesday, April 22, at 12:00 noon.

The speaker will be Dr. J. Park Biehl, research fellow and instructor in medicine, University of Cincinnati College of Medicine, and his subject will be "Experiences in the Management of Tuberculous Meningitis."

Officers of the Ohio Chapter are: Dr. H. J. Nimitz, Cincinnati, president, and Dr. Harold G. Curtis, Cleveland, secretary and treasurer.

2:15 to 2:30

PREMATURE CLOSURE OF THE CRANIAL SUTURES—A REVIEW

Frederic N. Silverman, M. D., Cincinnati.

2:30 to 3:00

THE TREATMENT OF LEUKEMIA AND LYMPHOMA

Richard H. Chamberlain, M. D., Philadelphia, Pa., Professor of Radiology, University of Pennsylvania School of Medicine.

3:00 to 4:00

FILM READING SESSION

Moderator: Joseph Morton, M. D., Columbus, Associate Professor of Radiology, Ohio State University College of Medicine.

Participants: Carroll C. Dundon, M. D., Cleveland; Lee S. Rosenberg, M. D., Cincinnati; Austin J. Brogan, M. D., Dayton; Dr. Chamberlain.

4:00 to 4:10

Business Session. Report of Nominating Committee. Election of Officers.

4:10 to 6:00

TOUR OF EXHIBITS

WEDNESDAY, APRIL 22

2:00 P. M.

SECTION ON GENERAL PRACTICE

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Earl C. Van Horn, M. D., Cincinnati ..... Chairman
S. D. Nielsen, M. D., Elyria ..... Secretary

PRACTICAL TIPS FOR BUSY GENERAL PRACTITIONERS

2:00 to 2:30

NEEDLE THERAPY

Andrew S. Tomb, M. D., Victoria, Texas, Past-President, Texas Academy of General Practice.

2:30 to 2:45

INDUSTRIAL WORK

Joseph C. Lindner, M. D., Cincinnati.

2:45 to 3:00

PATIENT REFERRAL

Thomas E. Rardin, M. D., Columbus.

3:00 to 3:15

GETTING PAID FOR PRACTICE

Mr. Stanley R. Mauck, Columbus.

3:15 to 3:30

COMMUNITY ACTIVITIES

Edmond K. Yantes, M. D., Wilmington.

3:30 to 4:00

QUESTION AND ANSWER PERIOD.

4:00 to 4:10

Business Session. Report of Nominating Committee. Election of Officers

4:10 to 6:00

TOUR OF EXHIBITS

WEDNESDAY, APRIL 22

7:30 P. M.

ANNUAL BANQUET

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

MUSIC DANCING
ENTERTAINMENT

THURSDAY, APRIL 23

8:00 A. M.

REGISTRATION

Fourth Floor Foyer
Netherland Plaza Hotel

THURSDAY, APRIL 23

8:30 A. M. to 9:15 A. M.

MEDICAL MOTION PICTURES

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: Donald B. Effler, M. D., Cleveland, Chairman, Committee on Motion Pictures.

URINARY INFECTIONS—BACTERIOLOGY—PATHOLOGY—TREATMENT

Grayson Carroll, M. D., St. Louis, Mo., Associate Professor of Urology, St. Louis University Medical School.
Commentator: Arthur T. Evans, M. D., Cincinnati.

THURSDAY, APRIL 23

9:30 A. M.

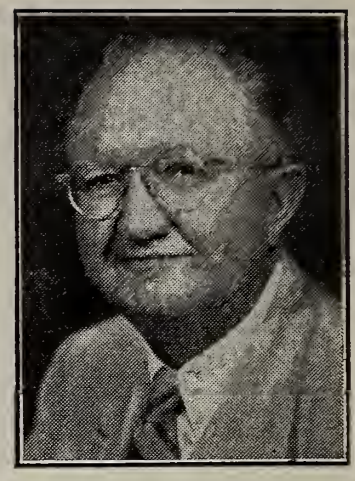
GENERAL SESSION

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: Louis G. Herrmann, M. D., Cincinnati, Member, Committee on Scientific Work.



JOS. B. KIRSNER, M. D.
Chicago



L. R. DRAGSTEDT, M.D.
Chicago

9:30 to 10:00

MEDICAL MANAGEMENT OF PEPTIC ULCER

Joseph B. Kirsner, M. D., Chicago, Ill., Professor of Medicine, University of Chicago, The School of Medicine.

10:00 to 10:30

SURGICAL MANAGEMENT OF PEPTIC ULCER

Lester R. Dragstedt, M. D., Chicago, Ill., Thomas D. Jones Distinguished Service Professor and Chairman, Department of Surgery, University of Chicago, The School of Medicine.

10:30 to 11:15

INTERMISSION TO TOUR EXHIBITS

THURSDAY, APRIL 23

11:15 A. M.

GENERAL SESSION

Pavillon Caprice, Fourth Floor
Netherland Plaza Hotel

Presiding: Robert M. Zollinger, M. D., Columbus, Member, Committee on Scientific Work.

11:15 to 12:00

THE TREATMENT OF CORONARY HEART DISEASE

Charles K. Friedberg, M. D., New York, N. Y.

12:00 to 12:45

SURGICAL THERAPY IN PORTAL HYPERTENSION WITH PARTICULAR REFERENCE TO SELECTION OF CASES

Louis M. Rousselot, M. D., New York, N. Y., Professor of Clinical Surgery, New York University College of Medicine.

(Note: Exhibits will remain open until 3:00 P. M.)

THURSDAY, APRIL 23

1:00 P. M.

HOUSE OF DELEGATES

LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES TO BE FOLLOWED BY THE FINAL BUSINESS SESSION

Parlors A, B, C, D, Fourth Floor
Netherland Plaza Hotel

Additional Annual Meeting Features . . .

Psychiatric Association To Meet In Cincinnati, April 20-21

The Ohio Psychiatric Association will hold its annual meeting in Cincinnati April 20-21, which is during the week of the Annual Meeting of the Ohio State Medical Association. Place of the meeting has not been selected, but will be announced later, according to Dr. Philip C. Rond, secretary-treasurer, Columbus Receiving Hospital, Ohio State University, Columbus. The program for the society's meeting follows:

MONDAY, APRIL 20

2:00 p. m.—Manic State as Emergency Defense Reaction; Drs. Agoston, Kovitz and McCullough

2:30 p. m.—Fifteen Year Report of Insulin Shock Therapy at Toledo State Hospital; Dr. J. B. Koupal

3:00 p. m.—Origin of Cerebral Rhythmic Activity; Dr. Andre Weil

3:30 p. m.—Case Report of Acute and Fatal Alarm Reaction; Drs. Whieldon, Smith and Ellis

Reservations have been tentatively made for a party on Monday evening, April 20, which will include trip up the Ohio river and roast beef dinner at 6.00 p. m. Make reservations by writing to Dr. Robert W. Buckley, 2540 Auburn Ave., Cincinnati 19, Ohio. Capital 1050.

TUESDAY, APRIL 21

9:30 a. m.—Role of Parents in the Emotional Growth of Children; Dr. Charles Bohnengel

10:00 a. m—Day Hospital Unit—It's Place in the Treatment of the Mental Ill; Dr. Philip Rond

10:30 a. m.—The Therapeutic Application of Anti-Convulsant Medications to Psychotic States; Dr. Milton Parker

11:00 a. m.—Use of Artistic Expression in the Psycho-Therapeutic Process; Dr. Hoffman and Miss MacDonald, O. T.

1:30 p. m.—Changing Concepts of the Psychology of Aging; Dr. Lawrence F. Greenleigh

2:00 p. m.—Psychiatric Orientation in a Juvenile Court Session; Drs. Langsam and Markey

2:30 p. m.—The Influence of the Hospitals Psychological Environment on the Clinical Status of the Patient; Dr. Stanley M. Kaplan and John W. Higgins

3:00 p. m.—Psychodramatic Techniques; Dr. Wm. E. Moore

Alternate Papers: 1. The Electro-Encephalogram in Children who have experienced a paralysis after seizure (Dr. Whieldon).

2. Genesis Dynamism and psychotic reaction in the aged (Drs. Agoston and Wedemeyer).

3. Square dancing in a State Hospital—A re-socializing activity (Dr. Burman H. Preston).

Excellent Scientific Exhibit Being Planned

One of the outstanding features of the Annual Meeting, April 21-23, Cincinnati, will be the Scientific and Educational Exhibit at the Netherland Plaza Hotel.

The Committee on Scientific and Educational Exhibit expects to have about 40 exhibits on display. If possible, the list of exhibits will be published in the April issue of *The Journal*. Of course, they will be listed in the pamphlet program which will be given to all who register.

You can't afford to miss this feature of the meeting.

Heart Association Will Give Program In Cincinnati, April 23

The Ohio State Heart Association and its affiliates are presenting a program for the medical profession on Thursday afternoon, April 23, from 2:00 until 4:30 P. M. in the Victory Room, Hotel Gibson, Cincinnati, it has been announced by R. W. Kissane, M. D., of Columbus, Chairman of the Program Committee.

A series of six fifteen-minute papers will be given with five minute discussion periods after each paper. Subjects and participants will be:

Acute Rheumatic Fever, Carl Weihl, M. D., assistant professor of pediatrics, University of Cincinnati; Coronary Artery Disease, A. Carlton Ernstene, M. D., chief, Division of Medicine, Cleveland Clinic; Congestive Heart Failure, Johnson McGuire, M. D., director, Cardiac Laboratory, associate professor, University of Cincinnati; Congenital Heart Disease, Maurice A. Schnitker, M. D., president, Northwestern Ohio Heart Association, chief of staff, Maumee Valley Hospital, Toledo; Cardiac Surgery, H. William Clatworthy, M. D., associate professor pediatric surgery, Ohio State University, attending surgeon, Children's and University Hospitals, Columbus; Hypertension, Irvine H. Page, M. D., director of research, Cleveland Clinic Foundation and president of the Cleveland Area Heart Society.

Bernard A. Schwartz, M. D., president, Ohio

State Heart Association, assistant clinical professor of medicine, University of Cincinnati, will preside.

Dr. Kissane points out that the program has been keyed for the General Practitioner but all doctors are welcome to attend. There will be no charge or registration fees.

Serving with Dr. Kissane on the Program Committee of the Ohio State Heart Association are Dr. Harold Feil, Cleveland; Dr. J. Harold Kotte, Cincinnati; and Mrs. O. W. Haulman, Youngstown.

Excellent Practical Program Arranged For Conference of County Society Officials and Committeemen In Cincinnati, April 20

A program of practical value to officials and chairmen of certain committees of all County Medical Societies has been arranged for the conference which will be held on Monday afternoon, April 20, at the Netherland Plaza Hotel, Cincinnati—the day immediately preceding the 1953 Annual Meeting of the Ohio State Medical Association, April 21-23.

These topics will be discussed by the persons indicated and there will be ample time for questions and a general discussion from the floor:

"Doctors and the Military Situation," Mr. C. Joseph Stetler, secretary, Council on Emergency Medical Service, American Medical Association, Chicago.

"Medical and Hospital Care Programs for Recipients of Public Assistance," Mr. Robert Canary, chief, Division of Social Administration, Ohio Department of Welfare, Columbus.

"Medical and Hospital Care Programs for Recipients of Aid for the Aged," representative of the State Division of Aid for the Aged (to be named).

"State and Federal Legislation," Mr. Charles S. Nelson, Executive Secretary, Ohio State Medical Association, Columbus.

Special invitations to the conference have been issued to the President, Secretary, Military Advisory Committee chairman, Legislative Chairman, and chairman of the local committee dealing with relief and welfare agencies of each County Medical Society. Invitations have been issued also to State Association officials and members of corresponding state committees.

Those receiving invitations will be expected to attend a complimentary luncheon at 12:00 Noon. The program will start at 1:30 P.M. Members not receiving an invitation will be welcome at the 1:30 P.M. session. **Attendance at the luncheon will be by invitation only.**

All persons expecting to attend the luncheon should notify the Columbus Office so an adequate number of luncheon reservations may be made.

The luncheon and the afternoon program will be held in the Pavillon Caprice, Fourth Floor, Netherland Plaza Hotel.

Those planning to attend this conference, who are contemplating remaining over for the Annual Meeting which will open Tuesday morning, April 21, should engage hotel space for Monday night.

Banquet Tickets May Be Ordered By Mail

Tickets for the Annual Banquet, Ohio State Medical Association, the evening of April 22, at the Netherland Plaza Hotel, may be ordered by mail from the Columbus Office, 79 East State Street, Columbus 15.

Price of each ticket will be $6.50, including dinner, tax, tips and entertainment.

When ordering tickets, please print your name and address and enclose a check for the total price of tickets ordered.

A mailing piece which will be sent to all members in the near future will include a blank for ordering banquet tickets and a return envelope. Watch for it.

Motion Pictures To Be Shown Daily at Meeting

A program of medical motion pictures is one of the new features of the 1953 Annual Meeting, Cincinnati, April 21-23.

Pictures will be shown each morning from 8:30 to 9:15 A.M. in the Pavillon Caprice, Netherland Plaza Hotel. They have been carefully selected by a special committee. There will be a "live" commentator for each picture.

Don't miss this new feature of the Annual Meeting program.

Jefferson Alumni Plan Reunion In Cincinnati, April 21

Alumni of Jefferson Medical College will hold a dinner get-together at Town and Country, 1622 Dixie Highway, Covington, Kentucky, on the evening of April 21, during the week of the Annual Meeting of the Ohio State Medical Association in Cincinnati.

The reunion of Ohio physicians who are graduates of Jefferson Medical College will start at

6:00 P. M. with a social hour. Dinner will be served at 7:00 P. M.

At 8:00 P. M. there will be an informal meeting. The President of the Jefferson Medical College National Alumni Association, the Dean of the College, and another prominent faculty member will be guests and will make short talks.

Chairman of the affair is Dr. Robert J. Anzinger, 4125 Hamilton Avenue, Cincinnati 23. Reservations, at popular prices, may be made through Dr. Anzinger. Town and Country is only a 15-minute taxi ride from the Netherland Plaza Hotel, the headquarters of the Ohio State Medical Association meeting.

Reserve and Affiliated Hospitals Form Joint Executive Agency

Western Reserve University and University Hospitals, its affiliated medical center, have formed a new administrative structure which brings together the top four authorities of both institutions to operate as a joint executive body.

The move creates a composite executive agency charged with making joint administrative decisions in areas common to the two institutions and exercising executive responsibilities in concert with each other. It is believed to be the first undertaking of its kind in the country.

TECHNICAL EXHIBITORS

HALL OF MIRRORS, THIRD FLOOR: NORTH HALL, FOURTH FLOOR
NETHERLAND PLAZA HOTEL, CINCINNATI

Open from 9:00 A. M. to 6:00 P. M. on Tuesday, April 21, and Wednesday, April 22; and from 9:00 A. M. to 3:00 P. M. on Thursday, April 23

Exhibitor	Address	Booth Number
Abbott Laboratories	North Chicago, Ill.	23
Aloe, A. S., Company	St. Louis, Mo.	70
Americana Corporation	Chicago, Ill.	74
Ames Company, Inc.	Elkhart, Ind.	7
Archibald, E. D., Company	Cleveland, Ohio	47
Ayerst, McKenna & Harrison, Limited	New York, N. Y.	30
Baby Development Clinic	Chicago, Ill.	60
Baker Laboratories, Inc., The	Cleveland, O.	57
Beech-Nut Packing Co.	New York, N. Y.	65
Borden Company, The	New York, N. Y.	69
Bowman Bros. Drug Co., The	Canton, Ohio	21
Burroughs Wellcome & Company (U. S. A.), Inc.	Tuckahoe 7, N. Y.	43
Caldwell & Bloor Company, The	Mansfield, Ohio	68
Camel Cigarettes	New York, N. Y.	2, 3
Campbell Associates	Cincinnati, Ohio	55
Chicago Pharmacal Company	Chicago, Ill.	27
Chilcott Laboratories	Morris Plains, N. J.	75
Ciba Pharmaceutical Products, Inc.	Summit, N. J.	37
Coca-Cola Company, The	Atlanta, Ga.	48
Columbus Hospital Supply Co.	Columbus, O.	42
Denver Chemical Manufacturing Company, Inc., The	New York, N. Y.	4
Eaton Laboratories, Inc.	Norwich, N. Y.	53
Endo Products, Inc.	Richmond Hill, N. Y.	25
Fleet, C. B., Company, Inc.	Lynchburg, Va.	36
Freeman Manufacturing Co.	Sturgis, Mich.	62
General Electric Company, X-Ray Department	Cincinnati, Ohio	9, 10
Gerber Products Company	Fremont, Mich.	58
Heinz, H. J., Company	Pittsburgh, Pa.	77
Holland-Rantos Company, Inc.	New York, N. Y.	59
Kelley-Koett Manufacturing Company, The	Covington, Ky.	17, 18
Kremers-Urban Company	Milwaukee, Wis.	5
Lanteen Medical Laboratories, Inc.	Evanston, Ill.	31
Lederle Laboratories Div., American Cyanamid Company	New York, N. Y.	40
Liebel-Flarsheim Company, The	Cincinnati, Ohio	6
Lilly, Eli, & Company	Indianapolis, Ind.	28
Lippincott, J. B., Company	Philadelphia, Pa.	51
M & R Laboratories	Columbus, Ohio	12
Massengill, S. E., Co., The	Bristol, Tenn.	35
Mead Johnson & Company	Evansville, Ind.	22
Medical Protective Company, The	Fort Wayne, Ind.	24
Merrell, William S., Co., The	Cincinnati, O.	41
Miller Surgical Company	Chicago, Ill.	14
Mueller, V., & Company	Chicago, Ill.	34
Ortho Pharmaceutical Corporation	Raritan, N. J.	66
Parke, Davis & Company	Detroit, Mich.	8
Pet Milk Company	St. Louis, Mo.	29
Pfizer, Charles, & Co., Inc.	Brooklyn, N. Y.	52
Philip Morris & Company, Limited, Inc.	New York, N. Y.	46
Procter & Gamble Company	Cincinnati, O.	50
Robins, A. H., Company, Inc.	Richmond, Va.	71

Exhibitor	Address	Booth Number
Sanborn Company, Cambridge, Mass.		44
Sandoz Pharmaceuticals, New York, N. Y.		45
Saunders, W. B., Company, Philadelphia, Pa.		73
Schering Corporation, Bloomfield, N. J.		56
Sealy Mattress Company, Cleveland, Ohio		76
Searle, G. D., & Company, Chicago, Ill.		13
Sharp & Dohme, Inc., Philadelphia, Pa.		16
Smith, Kline & French Laboratories, Philadelphia, Pa.		11
Squibb, E. R., & Sons, Long Island City, N. Y.		72
Stuart Company, The, Chicago, Ill.		15
Testagar & Company, Inc., Detroit, Mich.		54
Travenol Laboratories, Inc., Morton Grove, Ill.		61
U. S. Vitamin Corporation, New York, N. Y.		19
Upjohn Company, The, Kalamazoo, Mich.		38
Vaisey-Bristol Shoe Co., Inc., Rochester, N.Y.		33
Varick Pharmacal Co., Inc., New York, N. Y.		49
Warren-Teed Products Co., Columbus, O.		1
Wendt-Bristol Co., The, Columbus, Ohio		26
Westinghouse Electric Corporation, Baltimore, Md.		39
Winthrop-Stearns, Inc., New York, N. Y.		32
Wocher, Max, & Son Company, The, Cincinnati, Ohio		63, 64
Wyeth, Inc., Philadelphia, Pa.		67
Zimmer Manufacturing Co., Warsaw, Ind.		20

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	S. J. Ellison	R. C. Wenrick
BROWN	George P. Tyler, Jr.	Glenn S. Lamkin
BUTLER	C. T. Atkinson	William U. Neel
	Neil Millikin	John A. Carter
CLERMONT	A. A. Gruber	J. M. Coleman
CLINTON	E. K. Yantes	R. R. Buchanan
HAMILTON	Richard D. Bryant	Charles D. Bahl
	Edward C. Elsey	Joseph G. Crotty
	Harry L. Fry	John W. Devanney, Jr.
	Joseph C. Lindner	John G. Fleming
	John H. Payne	Harry K. Hines
	W. O. Ramey	J. Robert Hudson
	Daniel C. Rivers	J. Harold Kotte
	Robert C. Rothenberg	Virgil A. Plessinger
	Foster M. Williams	Robert J. Tapke
	Robert M. Woolford	Carl F. Vilter
HIGHLAND	John R. McBride	G. Lyle Morris
WARREN	O. L. Layman	John E. Sharts
SECOND DISTRICT		
CHAMPAIGN	I. Miller	V. R. Frederick
CLARK	Martin J. Cook	E. W. Schilke
	R. M. Turner	J. H. Shanklin
DARKE	J. E. Gillette	G. E. Sayle
GREENE	H. C. Messenger	R. D. Hendrickson
MIAMI	G. A. Woodhouse	K. F. Lowry
MONTGOMERY	R. D. Dooley	J. M. Shaffer
	R. C. Doan	Ned. D. Shepard
	A. W. Carley	R. E. Pumphrey
	H. M. James	L. E. Baker
	T. L. Light	W. H. Hanning
PREBLE	E. P. Trittschuh	B. R. Smith
SHELBY	H. E. Crimm	J. W. Tirey
THIRD DISTRICT		
ALLEN	E. B. Young	T. D. Allison
AUGLAIZE	Guy E. Noble	T. H. Will
CRAWFORD		
HANCOCK	Frank M. Wiseley	John F. Roth
HARDIN	Floyd M. Elliott	Louis A. Black
LOGAN	H. L. Mikesell	D. W. Beach
MARION		
MERCER	Rudolph G. Schmidt	Robert M. Fell
SENECA	R. F. Machamer	P. J. Leahy
VAN WERT	R. H. Good	H. D. Underwood
WYANDOT	J. Craig Bowman	F. M. Smith
FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	H. J. Wenzinger
FULTON		
HENRY	B. L. Johnson	Thomas W. Quinn
LUCAS	W. W. Green	F. F. Rawling
	C. R. Forrester	M. E. Green
	D. C. Frick	H. E. Smith
	C. L. Felker	W. A. Baird
	G. H. Start	C. S. Wohl
OTTAWA	George A. Boon	C. R. Wood
PAULDING	D. E. Farling	G. L. Doster
PUTNAM	A. P. Daniel	M. B. Rice
SANDUSKY	J. W. Monahan	R. R. Wilson
WILLIAMS		
WOOD	Paul F. Orr	R. N. Whitehead
FIFTH DISTRICT		
ASHTABULA	P. J. Collander	A. A. DeCato
CUYAHOGA	John H. Budd	F. L. Browning
	G. G. Bassett	J. B. Hazard
	J. K. Doran	D. A. Kelly
	H. A. Haller	W. H. McGaw
	C. A. Hamann	L. J. Perme
	S. O. Hoerr	F. J. Rack
	C. R. Jablonoski	G. L. Sackett
	F. R. Kelly	D. K. Spitler
	E. A. Marshall	S. E. Wolpaw
	P. A. Mielcarek	
	G. W. Petznick	
	J. M. Rossen	
	H. W. Salter	
	P. J. Schildt	
	R. J. Whitacre	
GEAUGA	W. A. Reed	H. E. Shafer
LAKE	M. G. Carmody	B. S. Park
SIXTH DISTRICT		
COLUMBIANA	J. A. Fraser	P. H. Beaver
MAHONING	S. W. Ondash	M. W. Neidus
	I. C. Smith	Asher Randell
	W. M. Skipp	A. A. Detesco
PORTAGE	Albert L. Tsai	H. B. Elwell, Jr.
STARK	R. H. Clunk	C. V. Smith
	L. L. Dowell	J. R. Rohrbaugh
	R. L. Rutledge	C. S. Palmer
SUMMIT	Frank T. Moore	Patrick C. Doran
	Edgar C. Pickard	John A. Campbell
	Carl C. Nohe	Richard H. Stahl
	A. William Friend	James W. German
TRUMBULL	A. L. Williamson	S. J. Shapiro
SEVENTH DISTRICT		
BELMONT	R. A. Porterfield	Peter Lancione
CARROLL	J. D. Stires	Glenn C. Dowell
COSHOCTON	William E. Pfaadt	J. C. Briner
HARRISON	Carl F. Goll	G. E. Henderson
JEFFERSON	S. L. Burkhardt	Earl I. Rosenblum
MONROE	A. R. Burkhart	
TUSCARAWAS	H. E. Reed	P. W. Ebert

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
EIGHTH DISTRICT		
ATHENS	A. A. Baldwin	E. A. Sprague
FAIRFIELD	L. E. Stenger	S. C. Sneeringer
GUERNSEY	James A. L. Toland	O. R. Martin
LICKING	R. G. Plummer	James B. Johnson, Jr.
MORGAN		
MUSKINGUM	A. C. Ormond	J. H. Bain
NOBLE	N. S. Reed	E. G. Ditch
PERRY		
WASHINGTON	Edgar Northrup	Deane H. Northrup
NINTH DISTRICT		
GALLIA	H. B. Thomas	W. L. Brown
HOCKING	C. T. Grattidge	R. C. Jones
JACKSON	C. C. Fitzpatrick	W. T. Washam
LAWRENCE	George N. Spears	Thomas E. Miller
MEIGS	S. J. Blazewicz	R. P. Daniels
PIKE	R. M. Andre	C. L. Critchfield
SCIOTO	O. D. Tatje	R. L. Wagner
VINTON	H. D. Chamberlain	
TENTH DISTRICT		
DELAWARE	E. C. Jenkins	F. M. Stratton
FAYETTE		
FRANKLIN	H. B. Davidson	Robert C. Kirk
	John E. Martin	Frank A. Riebel
	Charles W. Pavey	Judson D. Wilson
	H. H. Schwarzell	George O. Kress
	William F. Bradley	Joseph M. Gallen
	Robert E. S. Young	Robert M. Inglis
	James H. McCreary	Helen P. Graves
KNOX	Henry T. Lapp	R. S. Lord
MADISON	Wm. T. Bacon	E. S. Crouch
MORROW	J. P. Ingmire	Wm. S. Deffinger
PICKAWAY	W. F. Heine	Ray Carroll
ROSS	R. W. Holmes	H. M. Crumley
UNION	E. J. Marsh	F. C. Callaway
ELEVENTH DISTRICT		
ASHLAND	M. A. Shilling	R. P. Bogniard
ERIE	E. J. Meckstroth	R. H. Williamson
HOLMES	N. P. Stauffer	A. J. Earney
HURON	C. J. Cranston	O. J. Nicholson
LORAIN	Leonard Stack	S. D. Nielsen
	Theodore Berg	Charles R. Meek
MEDINA	H. T. Pease	
RICHLAND	F. M. Wadsworth	C. O. Butner
WAYNE	W. R. Schultz	L. A. Adair

OFFICERS

Pres.	H. M. Clodfelter	Treas.	R. L. Meiling
Pres.-Elect	Paul A. Davis	Past-Pres.	Fred W. Dixon

COUNCILORS

District		District	
First	D. W. Heusinkveld	Seventh	R. J. Foster
Second	Merrill D. Prugh	Eighth	R. S. Martin
Third	James R. Jarvis	Ninth	J. P. McAfee
Fourth	Carll S. Mundy	Tenth	Wm. F. Mitchell
Fifth	Charles L. Hudson	Eleventh	John S. Hattery
Sixth	Carl A. Gustafson		

Dr. Nulsen Named to Neurosurgery Chair at Western Reserve

Dr. Frank E. Nulsen, assistant professor of neurosurgery, University of Pennsylvania Medical School, Philadelphia, has been named to fill the newly created Harvey Huntington Brown, Jr., chair in neurosurgery at Western Reserve University School of Medicine.

The chair was made possible by a bequest from the late Mr. Brown who gave generously of his time and money in the interest of the university. Others have added to the fund.

A graduate of Harvard Medical School, Dr. Nulsen served with the Army Medical Corps during World War II at Cushing Hospital, near Boston. After the war, he continued his studies in neurosurgery in Chicago and New Haven. He was appointed chief resident in neurosurgery at the University of Pennsylvania Hospital in 1948 and the following year was appointed to the faculty of the Medical School.

Nuclear Studies Institute

An advanced course in autoradiography and three basic courses in radioisotope techniques will be given by the Oak Ridge Institute of Nuclear Studies. The autoradiography course will be held June 15-25, and the basic courses of four weeks duration will begin on June 8, July 6 and August 10. Application forms and additional information may be obtained from the Special Training Division, Oak Ridge Institute of Nuclear Studies, P. O. Box 117, Oak Ridge, Tenn.

New Bulletin Discusses Emergency Blood Transfusions

Minimal procedures for blood transfusion in civil defense emergencies are outlined in *Civil Defense Technical Bulletin* TB-11-5, dated November 1952.

The bulletin describes "Ideal Conditions for Blood Transfusion"; the "O-P Phase," which is the initial emergency period when only O blood and plasma can be relied upon, and outlines certain recommendations for that phase.

Other subjects discussed are the "Transistional" and "Recovery" phases; "Group-Specific Transfusions"; "Processing Blood Outside a Disaster Area."

"Emergency Processing of Blood in or Near a Disaster Area"; "Crossmatching in or near a Disaster Area"; "Administration of Blood"; and "Complications of Blood Transfusions."

The bulletin is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., and the price is five cents per copy.

Another bulletin in this series, *Civil Defense Technical Bulletin* TB-11-6, dated November 1952, is entitled: "Emergency Blood Grouping Laboratory Techniques." It is available on the same basis as the first-mentioned item, and for the same price.

It briefly describes laboratory methods for the determination of blood groups and Rh types recommended by the Division of Medical Sciences, National Research Council, for use in major disasters.



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1953 Annual Meeting
Ohio State Medical Association
Cincinnati, Ohio . . . April 21, 22, 23

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BED
NETHERLAND PLAZA HOTEL	$5.50-12.00	$10.00-12.50	$10.50-15.50
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Mail the coupon to hotel selected

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You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 21, 22, 23, 1953, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Suite

Arriving April.....at.....A. M..... P. M.

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.....

Doctors and the War . . .

Twenty-four Ohio Priority No. 3 Doctors Scheduled To Be Called For Active Duty in March; Proposal To Revise Doctor Draft Act Studied

OHIO will be expected to supply the armed forces with its first group of Priority No. 3 physicians in March.

A communication on this was sent to members of the State Military Advisory Committee and to the Military Advisory Committee chairmen of all County Medical Societies on February 12 by Dr. Robert Conard, Columbus, chairman of the Ohio Military Advisory Committee. Dr. Conard's memorandum read as follows:

"The first induction call for Priority III registrants is being issued. None of these are essential. None are from smaller communities. The distribution is as follows: Cuyahoga 9; Hamilton 5; Montgomery 3; Franklin 2; Trumbull 2; Mahoning 2; Allen 1.

"The calls by Selective Service are in reverse order of age, on a statewide basis and at present calls are being limited to registrants under 36 years of age. Later calls may include older age groups.

SURVEY URGED

"It is important that your Committee survey the Priority III registrants in this age group and immediately file with your local boards, with copy to this office, Forms 1113 in any instance where the registrant is regarded as essential to community medical service or to the National Health, Safety and Interest.

"This should be done at once, securing the lists of Priority III's from local boards in order to avoid the possibility that any should be ordered up for induction on later calls before their essential status has been determined and made a matter of record. Where a registrant is rated essential, a definite date should be stated for termination of deferment and review before expiration.

WATCH CIVILIAN NEEDS

"Up to this time we have been dealing with registrants in Priority I and II where, unfortunately in some few instances the obligation incurred by the registrants to serve a definite period made it necessary to cut community service deeper than was desirable.

"In dealing with Priority III this factor does not have to be considered and we must give proper weight to civilian needs, which is the intent of the law.

"Any remaining registrants in Priority I and II currently deferred should be reviewed and made available if possible."

THINGS HAPPENING IN WASHINGTON

Reports from Washington indicate that things are beginning to churn with regard to legislation to renew the Doctors' Draft Law.

Following are excerpts from the February 16 issue of Washington Report on the Medical Sciences by Gerald G. Gross which reports proceedings at preliminary conferences being held by Department of Defense and describes some of the provisions of the tentative department proposal:

GROSS REPORTS

"Atmosphere was disquietingly polite Thursday at special conference in Pentagon held for express purpose of dissecting and seeking bugs in new doctor-draft bill soon to be introduced in Congress. Subject is highly controversial but few dissents were registered at the hearing, chiefly because conferees wished to report back to the national societies which they represented at Pentagon round table. If there is to be a tug of war over details of doctor-draft extension, it will come early this spring when public hearings are conducted by House and Senate Armed Services Committees. In the meantime, professional groups most concerned have a provisional bill—approved by Dept. of Defense but still subject to alteration—around which to build testimony for presentation in Congress.

"How to resolve problem of providing Army, Navy and Air Force with medical and dental officers required, at minimal inconvenience to civilian needs, is of vital importance to a variety of specialized interests. Primary concern is for clinical care, but also to be safeguarded are public health requirements; professional education; industrial health programs; medical research, and internship-residency training.

PROVISIONS OUTLINED

"Citing them in order of mention in proposed amendment to Public Law 779, here are highlights of bill draft discussed Thursday: Age ceiling is unchanged, remaining at 50 . . . doctor-draft is extended for two years, expiring June 30, 1955 . . . callup priority is essentially unchanged, with present I's and II's to be taken first, as they become available, with non-veterans next in order and, finally, veterans . . . the term "active military service" is clearly defined . . . eligibility of aliens for commissioning by military is established . . . duties of National Advisory Committee to Selective Service are spelled out

. . . rules on recall to active duty are liberalized for members of Reserve components who have had previous service.

Another interesting change—Physicians and dentists who submit to induction, thus forfeiting the $100 extra monthly pay given volunteers, may qualify for this "bonus" if they elect to serve in uniform beyond their obligated 24 months of duty.

STATISTICS REVIEWED

Decision by Dept. of Defense to keep draft age ceiling at 50 was based on analysis of statistics compiled by Selective Service on Priorities III and IV pools of physicians.

Official count shows 33,086 doctors of medicine in Priority III. In Priority IV are 51,735 physicians. All of these are special registrants under P. L. 779 and are exclusive of physicians who, having been Reservists at time of special registration more than two years ago, were not required to register with Selective Service.

Census reveals 9.6 pc. (3,191) of Priority III medical registrants 30 or younger; 7 pc. (2,318) in 31-35 class; 14.3 pc. (4,718) in 36-40; 25.3 pc. (8,368) in 41-45; 31.2 pc. (10,327) in 46-50, and 12.6 pc. (4,164) past age 50 and therefore beyond draft callup.

Of the special registrants in Priority IV, 50.8 pc. of the physicians have had at least 37 months of active military duty since 1940. This follows closely the pattern for the Priority IV-type members of Reserve pools who are non-registrants, 49 pc. of physicians having had 37 or more months of military service. Numerically, they total 15,682.

A. M. A. TESTIFIES

In behalf of A. M. A., Trustee David B. Allman said revision is "a step in the right direction," but suggested draft extension be for one year instead of two. He called for judicious utilization of medical personnel by the military and revealed that A. M. A. now favors creation of post of Assistant Secretary of Defense for Health Affairs. American Dental and American Veterinary Medical Associations indicated support of bill, in principle. Spokesmen for medical and dental education expressed hope that faculties will not be hit too hard under administration of a successor law to P. L. 779.

Medical Veterans Society, through its legislative representative, Dr. William B. Walsh, stressed that clear-cut policy should be adopted on terminal leave, as to its being counted as active duty. Walsh-MVS idea is that terminal leave should be creditable as active duty.

The nineteenth Annual Meeting of the American College of Chest Physicians will be held at the Hotel New Yorker, New York City, Thursday, May 28, through Sunday, May 31.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association since December 31, 1952. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY
Albertson, John D., Lima
Gavigan, Arthur, Lima
Maurer, Fred G., Jr., Lima
Netherton, Robert C., Lima

ATHENS COUNTY
Dutton, Genevieve Garrett, Athens
Dutton, Wayne

BELMONT COUNTY
Raimonde, Romeo A., Martins Ferry

BUTLER COUNTY
Egbert, Clarence H., Hamilton

CHAMPAIGN COUNTY
Polsley, John R., North Lewisburg

CLARK COUNTY
Fishbain, Harold, Springfield
Horton, George R., Springfield
Rimelspach, John J., Yellow Springs
Winterhoff, Ernest H., Springfield

CLERMONT COUNTY
Batsche, Joseph H., Batavia
Rockwell, Evelyn M., Milford

CLINTON COUNTY
Tabler, Thomas, Sabina

CUYAHOGA COUNTY
Bergstrom, Roberta F., Cleveland
Dvorak, June A., Cleveland
Gross, Gilbert L., Cleveland
Hazzard, Lawrence R., Jr. Cleveland
Kleinerman, Jerome N., Cleveland
McClelland, Jean N., Cleveland
McCubbin, James W., Cleveland
Patterson, Malcolm R., Cleveland
Robbins, Frederick C., Cleveland
Schiff, Edward J., Cleveland
Spencer, George E., Jr., Cleveland
Szakalum, Lawrence W. J., Cleveland

GEAUGA COUNTY
Hawk, Dale J., Chardon

GREEN COUNTY
Casebere, Louis E., Dayton
Salisburgy, Alvin B., Jr., Fairborn
Warner, Rodney D., Xenia

HAMILTON COUNTY
Baum, Gerald L., Cincinnati
Bauman, Paul H., Harrison
Buente, Louis C., Cincinnati
Hans, Clarence L., Jr., Cincinnati
Hiatt, Harold, Cincinnati
Moulton, James A. L., Cincinnati
Pagel, Ralph W., Cincinnati
Rubenstein, Edward, Cinnati
Wildman, Walter B., Cincinnati

HARRISON COUNTY
Scott, James Z., Scio

LORAIN COUNTY
Feicks, William J., Lorain

MARION COUNTY
MacPherson, Donald, Marion

MEDINA COUNTY
Avery, Richard, Seville

MERCER COUNTY
Fell, Robert, Celina

MONTGOMERY COUNTY
Garrard, Sterling D., Dayton
Garrison, George H., Dayton
Gineitis, Romuald, Dayton
Hertel, James C., Dayton
Kerth, Louis J., Vandalia
Lewis, William J., Dayton
Miller, Jerome H., Dayton
O'Brien, Charles E., Dayton
Schear, Burt E., Dayton
Skipton, Robert D., Dayton

MUSKINGUM COUNTY
Gilliotte, Benjamin W., Zanesville

PIKE COUNTY
Strain, Shelly M., Piketon

PUTNAM COUNTY
Clarke, William, Kalida

RICHLAND COUNTY
Loggins, James E., Mansfield

SCIOTO COUNTY
Fleming, Leroy N., Lucasville

STARK COUNTY
Campbell, Robert Evans, Arizona
Wantz, Gerald P., Massillon

UNION COUNTY
Butler, Richard B., Marysville
Fuller, Robert F., Marysville

VAN WERT COUNTY
Claassen, Leon G., Convoy

WARREN COUNTY
Marvin, Robert K., Waynesville
Van Harlingen, George, Lebanon

WAYNE COUNTY
Cottle, Ralph I., Wooster

Commission Reports . . .

Recommendations Pertaining to Industrial Commission, Rural Health and Welfare-Public Assistance Laws and Procedures Submitted To Legislature

THE Fifth Biennial Report of the Ohio Program Commission, covering activities for 1951-1952 was issued in January.

This bi-partisan commission, established by action of the Ohio General Assembly, is charged with investigating and obtaining information regarding problems of state and local government; and recommending plans for the solution of these problems.

Of interest to the medical profession are recommendations with regard to rural health, the Industrial Commission, and public assistance.

The recommendations of the Commision are merely suggestions to the legislative and executive branches of government and to political subdivisions, and are not necessarily accepted or acted upon by these agencies.

RURAL HEALTH

Classified under rural health are the following recommendations, which are the result of the Commission's action on a report from the Subcommittee on Health of the Committee on Agriculture and Natural Resources.

"It is recommended that adequate financing of the State Department of Health be provided to the end that the Department be enabled to fulfill its statutory requirements and to secure competent personnel in all areas.

"It is recommended that consideration be given to the importance of further voluntary consolidation of health districts.

"It is recommended that legislation be enacted to transfer the functions of hotel and restaurant inspection, and the operating funds therefor, from the office of the State Fire Marshal to the Department of Health, with the exception of inspection for fire hazards which is to be retained in the State Fire Marshal's Office."

WORKMEN'S COMPENSATION

Recommendations regarding Industrial Commission operations covered a number of categories. Among other items was a suggestion that lawyers and others who appear before the Industrial Commission in behalf of claimants or employers be subject to licensing by the Industrial Commission. This recommendation has now been adopted by a regulation of that body.

The Program Commission had several suggestions to offer with regard to claims, including:

"That the present application and notice of injury form be discarded and be replaced with a series of three forms that are in almost universal use: 1. Employer's First Notice of Injury; 2. Physician's Report; 3. Application for Compensation.

"That the law provide that the Commission prior to determination of compensability may commence the payment of compensation and nursing expense, and may guarantee payment of medical and other expense, immediately upon receipt of any one of the forms mentioned above when it appears that the claim is probably compensable, such payment not to be construed as an admission or determination of the compensability of the claim."

Under the system outlined above, each form would be mailed directly to the Commission by the party who fills it out. This would eliminate the situation wherein a doctor must write down answers to questions as to whether there is evidence of malingering or exaggeration and then hand the form back to the workman or his agent.

SAFETY PROGRAM

It was recommended that the Division of Safety and Hygiene make a study of the programs of accident prevention and occupational disease elimination conducted by employers and other agencies and adopt the features which have proven to be effective. Also that legislation be enacted to provide sufficient funds for the division to carry out such a program.

MEDICAL RECOMMENDATIONS

A number of actions were reported with regard to the medical aspects of Industrial Commission activities:

"That the salaries of doctors employed by the Commission be fixed at a level which is adequate to attract and retain sufficient competent personnel.

"That all personnel at the Industrial Commission engaged in the approval of medical bills, reviews of x-rays or determining of any medical issues, be located in and under the supervision of the Medical Section.

"That the Commission make full use of the now established rehabilitation centers in Cleveland, Dayton and Cincinnati, in addition to the Ohio State University Center; that the Commission pay to the centers the full costs of the services so furnished; that the Commission carefully screen all claims filed and when it appears to the medical department that rehabilitation is feasible that the attending physician be advised of the

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facilities available for rehabilitation; that the Commission and its medical department engage in a program of education to acquaint all physicians handling industrial claims of rehabilitation facilities available and the willingness of the Commission to pay for such services.

"That the Medical Department of the Commission give attention to and adopt simple rules of procedure so that nurses and doctors shall be promptly paid on all compensable claims, providing such bills are lawful and reasonable in amount."

PUBLIC ASSISTANCE

The Program Commission submitted without action the following suggestion of its Public Assistance Committee with regard to the State Department of Welfare:

"That the present Department of Welfare be divided into two separate departments. One Department to have charge of the preventive, curative, and custodial care of the mentally ill, the physically ill and the prisoners. The other department would have charge of the public assistance programs such as, but not limited to, Aid for the Aged, Aid for the Dependent Blind, and Aid for Widows and Dependent Children."

The Commission felt that the principle of consolidation of general relief administration into one county-wide agency is "sound and should be adopted if an equitable plan for financing can be developed locally."

ASK ENABLING LAW

It was recommended that the General Assembly consider the advisability of passing enabling legislation for the Aid for the Disabled Program. This is one of the Federally subsidized programs similar to Aid to Dependent Children, Aid to Blind, etc. It is not covered by specific enabling legislation, but operates only on the basis of an executive order of the State Welfare Director.

With regard to the admission of senile aged to mental institutions, the Commission recommended that legislation be enacted to give the state hospital superintendents the discretion to determine whether or not an aged person is a proper subject for admittance, since he is "the person best qualified to judge . . ."

It was further suggested that the local communities examine their responsibility for the care of the mild mental cases among the aged, and also for "providing of recreation, health care, housing, and employment facilities . . ."

As of June 30, 1952, veterans' population of the United States was 19,288,000.

Ike Comments on Health-Welfare Questions In Message

President Eisenhower's State of the Union message included the following recommendations on health and welfare:

Commission and Federal Security Administration Reorganization: "Health and Housing needs of our people call for intelligently planned programs. Involved, too, are the intricate matters of achieving proper Federal, state and local relationships; assuring the solvency of the whole security system; and guarding against its exploitation."

"To bring purpose and orderly procedure into this whole field, I anticipate a thorough study by an appropriate commission of the proper relationship among Federal, state and local programs in this whole field. I shall shortly send to you (Congress) specific recommendations for establishing such a commission, together with a reorganization plan defining new administrative status for all Federal activities in health, education, and social security."

The commission proposal is the same one advocated by Senator Taft. The President did not state specifically in this talk that he was proposing making the Federal Security Administration a cabinet department, but he is understood to favor this idea.

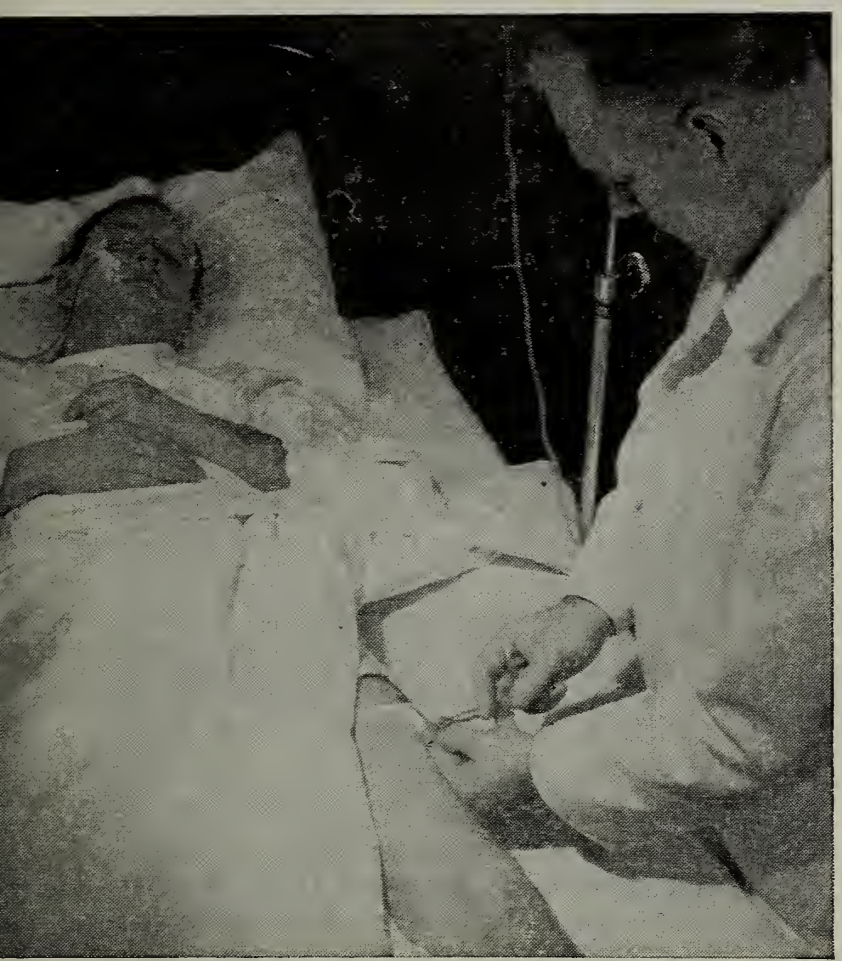
Pensions and Social Security: ". . . Provisions of the Old Age and Survivors Insurance Law should promptly be extended to cover millions of citizens who have been left out of the social security system. No less important is the encouragement of privately-sponsored pension plans.

The "privately-sponsored" pension plans apparently would include the Reed-Keogh principle for deferment of income taxes, a proposal previously specifically indorsed by the President.

Others: The President called attention to the country's traditional generosity in "caring for disabled—and the widow and orphan of the fallen." He did not, however, touch on such controversial issues as care of non-service cases or problems of Veterans Administration's medical department. . . . President Eisenhower asked Congress to act promptly to give Food and Drug Administration authority to make surprise inspections of factories, which a December Supreme Court ruling said F. D. A. could not continue to do under existing law. . . . He reaffirmed the Federal government's role in civil defense as one of furnishing leadership and technical guidance and of building up medical and other emergency stockpiles.

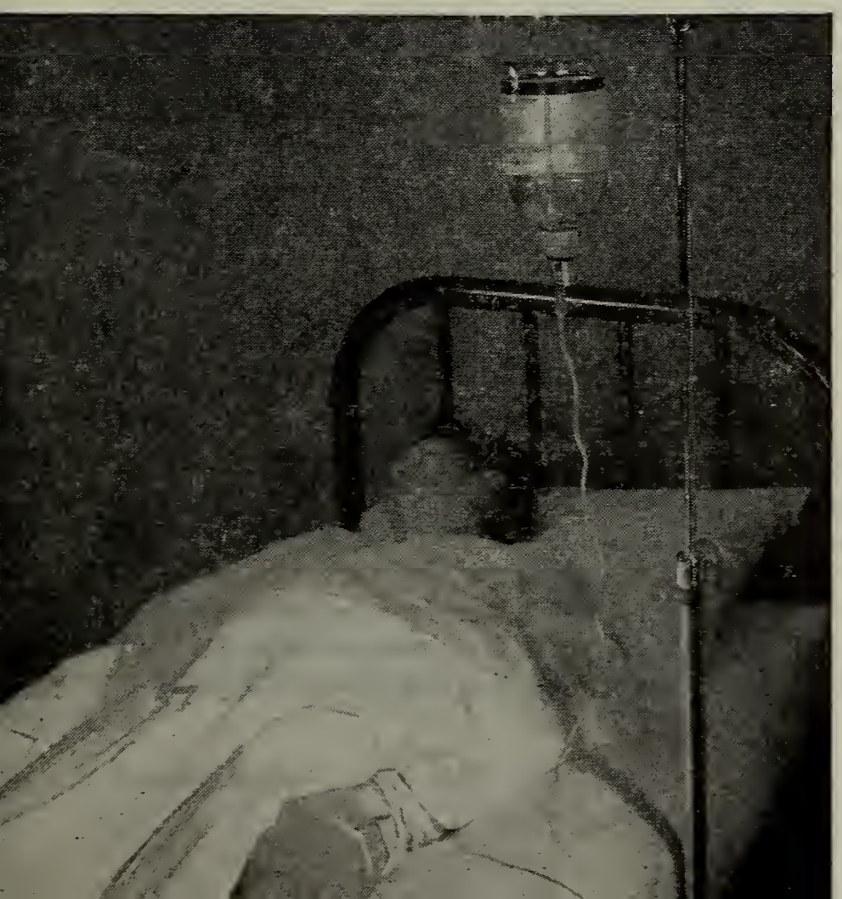
Participating in the V. A. home town medical and dental care programs on a fee-for-service basis during the year ending June 30 were 107,000 doctors of medicine; 7,000 doctors of osteopathy, and 62,000 dentists.

Use of Alidase® Permits Subcutaneous Administration of Fluids at Usual Intravenous Rates



In operative states—Alidase circumvents the complicating factors of venous thrombosis and "wornout" veins which frequently make fluid administration by vein difficult and dangerous. Simplicity and safety of Alidase make hypodermoclysis a method of choice for preoperative preparation and postoperative maintenance.

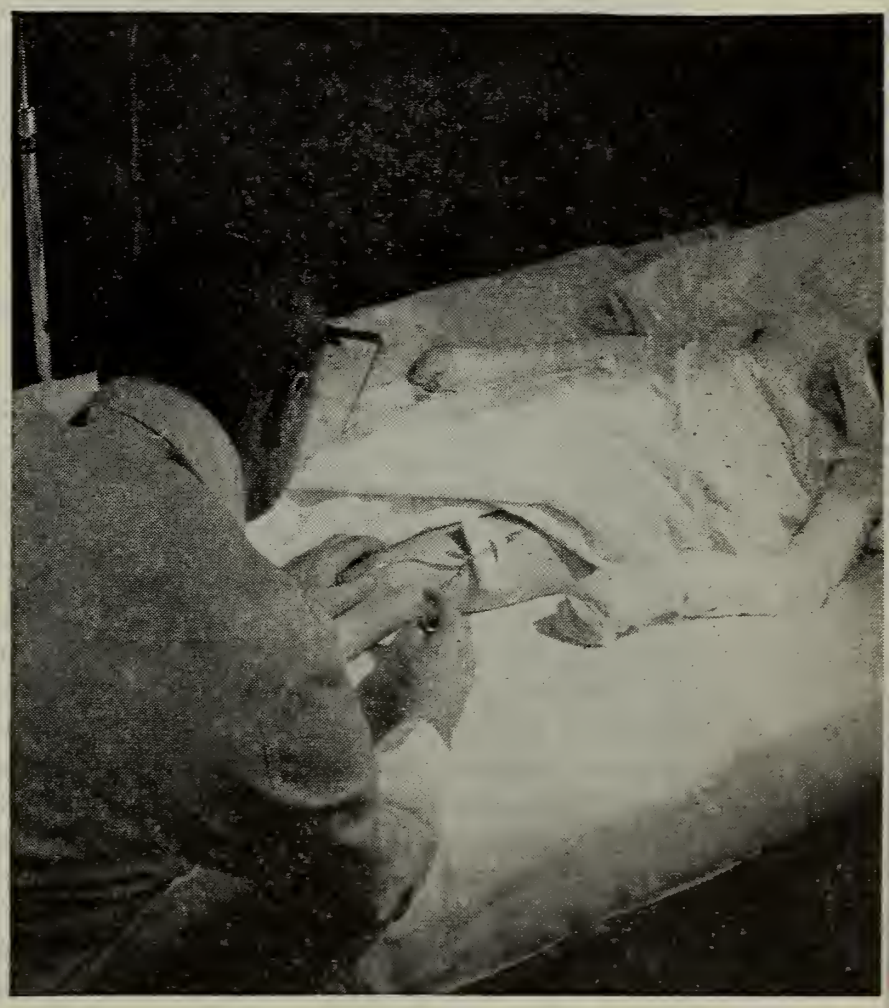
In burns—Plasma and electrolyte solutions can be given subcutaneously at effective rates when Alidase is employed; collapsed veins or risks of thrombosis are not a problem with this method.



Addition of Alidase to the first few cubic centimeters of fluid during hypodermoclysis speeds absorption to a degree approximating that of the intravenous route. Use of highly purified hyaluronidase in this manner avoids the well-known difficulties encountered with venoclysis, saves valuable nursing time and is more comfortable to the patient.

Hechter, Dopkeen and Yudell[1] have found that the use of hyaluronidase has "markedly increased the rates of absorption and administration of hypodermoclysis with no untoward reactions." They also found that extremely small amounts of this enzyme facilitated the absorption of fluids in that greater amounts of fluids were absorbed by the patient in a given period of time and that the localized swelling following hypodermoclysis disappeared more promptly.

Similar results with Alidase were recounted by Schwartzman, Henderson and King.[2] They observed "that absorption of various types of solutions, such as saline, glucose in saline, Hartmann's solution, Ringer's solution, penicillin, streptomycin, Adrenalin, and procaine was facilitated in every case."



In toxemias of pregnancy—Urgently-needed parenteral fluids may be administered subcutaneously with the aid of Alidase, eliminating risk of thrombosis attending repeated intravenous administration of electrolyte solutions. Alidase is the highly purified Searle brand of hyaluronidase and is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

G. D. SEARLE & Co. *Research in the Service of Medicine*

1. Hechter, O.; Dopkeen, S. K., and Yudell, M. H.: The Clinical Use of Hyaluronidase in Hypodermoclysis, J. Pediat. 30:645 (June) 1947.
2. Schwartzman, J.; Henderson, A. T., and King, W. E.: Hyaluronidase in Fluid Administration: A Preliminary Report, J. Pediat. 33:267 (Sept.) 1948.

Licenses Granted . . .

Right to Practice Medicine and Surgery in Ohio Is Granted by Medical Board to 52 Graduates of Medical Colleges Following December Tests

FORTY-EIGHT graduates of medical schools were authorized to receive certificates to practice medicine and surgery in Ohio, at a meeting of the State Medical Board on January 13, Dr. H. M. Platter, Secretary of the Board, announced. Certificates were issued on the basis of examinations taken December 1-3.

High grade in the examinations was made by William G. Pace, III, Reynoldsburg, a graduate of the University of Pennsylvania School of Medicine, with a grade of 91.1 per cent. The second highest grade was made by John A. Mitchell, Cleveland, a graduate of Cornell University Medical College, with 90.1 per cent. George A. Miller, Jr., Steubenville, a graduate of Northwestern University Medical School, Chicago, was third from the top with 89.9 per cent.

In addition to those licensed to practice medicine and surgery, there were 21 persons licensed to practice osteopathic medicine and surgery. In the limited fields, certificates were issued to the following: Nine chiropodists, 13 mechanotherapists, 15 chiropractors, nine masseurs and one cosmetic therapist.

Those authorized to receive licenses to practice medicine and surgery are the following, whose address and school of graduation are given:

Bella J. Ballo, Spencer, W. Va., Peter Pazmany University, Hungary; Jakub J. Biber, New York, University of Vienna; Robert J. Blough, Lima, Hahnemann Medical College; David R. Brown, Springfield, Medical College of Virginia;

Alexander Calder, Youngstown, New York Medical College; Vinson B. Conlifee, Selfridge Air Force Base, Detroit, Mich., Howard University College of Medicine; George A. Csanad, Cleveland, Peter Pazmany University, Hungary;

Charles Deme, Cleveland, University of Debrecen, Hungary; Arthur L. Dobosiewicz, Newark, N. J., University of Belgrade, Yugoslavia; Walerjan Doburzynski, Cincinnati, University of Wilno, Poland; Mark H. Eisenstadt, Staten Island, N. Y., Frederick Wilhelm University, Germany; Siegfried M. Epple, Cleveland, University of Tubingen, Germany; Robert C. Eyerly, Columbus, Jefferson Medical College;

Albert A. Fisk, Cleveland, Yale University School of Medicine; Joseph A. Fitzgerald, Lakewood, Loyola University; Robert J. Fredericks, Toledo, College of Medical Evangelists; Harold Gold, Cleveland, University of Toronto; Joachim H. Gruter, Cleveland, University of Heidelberg, Germany; Martin J. Gunter, Cleveland, University of Illinois;

Richard W. Juvancic, Youngstown, University of Pennsylvania; Joseph T. Kennedy, Cincinnati, University of Cincinnati College of Medicine; Laszlo Kolcsey, Cleveland, University of Szeged, Hungary; Juozas Kriauciunas, Cincinnati, University of Kaunas, Lithuania;

Adolfs K. Lazdins, Cleveland, University of Moscow; Thomas R. Leech, Lima, University of Pennsylvania; Maria L. Madi, Columbus, Peter Pazmany University, Hungary; Imre J. Magoss, Cleveland, University of Budapest, Hungary; Margita S. Magoss, Cleveland, University of Budapest; Ruth A. Maher, Columbus, Ohio State University College of Medicine;

Joseph Major, Wheeling, W. Va., University of Cluj, Rumania; Alexander L. McKay, Toronto, Canada, University of Toronto; Glen E. McPheron, Columbus, University of Cincinnati; George A. Miller, Jr., Steubenville, Northwestern University; John A. Mitchell, Cleveland, Cornell University; Julian Movchan, Elizabeth, N. J., University of Lemberg, Poland;

Sterling W. Obenour, Jr., E. Cleveland, Cornell University; William G. Pace, III, Reynoldsburg, University of Pennsylvania; Morris Plotnick, Cincinnati, Loyola University; Nellija Rubenis, Columbus, University of Riga, Litvia;

Longin Shankowsky, Cleveland, University of Cracow, Poland; James F. Sutherland, Cleveland, University of Pennsylvania; Henry Szancer, Staten Island, N. Y., University of Cracow, Poland; Bela Tapolczai, Cleveland, University of Pecs, Hungary; Rodger L. M. Taylor, Dayton, Meharry Medical College; Kenneth W. Turner, E. Liverpool, Jefferson Medical College;

Leopold Ukmar, Cleveland, University of Graz, Austria; Ymkje M. Van Erp, Cleveland, University of Leiden, Netherlands; Jaroslav Zanka, Toledo, Charles University.

Three Expelled By Academy

Three members of the Toledo Academy of Medicine have been expelled from membership by action of the Council of that society. They are: Dr. Stephen Donath and Dr. Louis R. Effler, who had been convicted in Federal Court of violating the Harrison Narcotic Act, and Dr. Roy A. Knisely, who had been convicted in Federal Court of violating the Federal Income Tax Law.

Voluntary Pension Plans . . .

Two Bills Before Congress Renew Efforts To Permit Tax Deferments For Physicians and Others on Investments in Retirement Annuities

DURING the first week of the 83d Congress bills were again introduced to permit tax deferments on amounts used to purchase retirement annuities. These measures, H. R. 10 and H. R. 11, which were introduced by Congressman Thomas A. Jenkins of Ohio and Congressman Eugene Keogh of New York, are identical with the "Keogh-Reed" bills of the 82d Congress.

The bills are designed to encourage the establishment of voluntary pension plans by individuals and to provide more equitable tax treatment for self-employed persons. The bills in their present form now include all the amendments suggested by the American Medical Association at hearings on the original legislation last May.

Through amendment of the Federal Internal Revenue Code, the bills would allow physicians and other self-employed individuals to deduct from their taxable income those amounts used each year to finance restricted retirement plans. Employed persons not covered by existing pension plans also would qualify for the tax deduction privilege.

Income received later during the years of retirement, either from pension funds or insurance annuities, would then be taxable under the prevailing rates. In other words, they provide tax deferment but not tax avoidance.

TO ELIMINATE DISCRIMINATION

Physicians, dentists, lawyers, architects, farmers, store owners and the many others who comprise the nation's self-employed have long been neglected in Federal tax legislation relating to pensions. The purpose of these bills is to eliminate the discrimination and inequities existing under present tax laws. By extending the tax deferment privilege to the country's ten million self-employed, and also to millions of employees who are not covered by pension plans, this new legislation will give them the incentive to save for old age during their best earning years.

Under Section 165 (a) of the 1942 Revenue Act, millions of employees covered by more than 16,000 approved pension plans are already receiving the benefit of pension tax deferment. They pay no tax during their working years on the employer's contribution to their retirement fund, even though it actually is extra compensation to the employee. After he retires, however, the employee must pay the tax on the part of the retirement benefit which was financed by the employer.

To provide a similar tax arrangement for self-employed persons, the bills would allow annual deductions of 10 per cent of earned net income, or $7,500, whichever is smaller. Total deductions during a taxpayer's lifetime could not exceed $150,000. The funds excluded from taxable income would have to be paid either to a trust fund established by an association for the benefit of its members or to an insurance company as premiums for a retirement annuity contract. In either case, no income payments or cash refunds could be made before the age of 65 except in cases of total disability or death.

WRITE CONGRESSMEN!

Ohio physicians who are interested in seeing the enactment of legislation like that described in the accompanying article should do two things:

1. Write to Congressman Thomas A. Jenkins, Ohio, at the House Office Building, Washington, D. C., advising him that they are very much interested in the enactment of his proposal and urging him to press for early hearings and favorable action.

2. Write to their own Congressman (if other than Mr. Jenkins), expressing interest in H. R. 10 and H. R. 11 and request him to give the measures active support.

In writing to Congressmen, members should briefly state their reasons for supporting these bills, using some of the material in the accompanying article as a basis.

The bills include a provision enabling persons already between the ages of 55 and 75 to make larger annual deductions than the basic 10 per cent or $7,500. This is a practical equivalent to the past service credits allowed in many employee pension plans. The bills also provide for a carry-over of unused deductions for a period up to five years. This is designed to give equitable treatment to persons with extreme fluctuations in income.

This legislation will be of particular benefit to physicians who go through a long and costly period of training and whose peak earnings are bunched into a comparatively short period of years when they are subject to high income tax rates.

This legislation, which has the approval of the American Medical Association and 20 other national organizations, can be enacted by the 83d Congress if physicians and all other self-employed persons work actively together for its passage.

New Auto Law In Effect . . .

Physicians Should Familiarize Themselves With Provisions of Stringent Motor Vehicle Safety Responsibility Act; Pertinent Sections Summarized

OHIO'S new Motor Vehicle Safety Responsibility Act became effective March 1.

Purpose of the law is "to eliminate the reckless and irresponsible driver from the highways and to provide for the giving of security and proof of financial responsibility by persons driving and owning motor vehicles."

All Ohio physicians should familiarize themselves with the provisions of this new law as it carries stringent provisions on reporting of accidents involving automobiles and on settlement of liability.

A copy of the law may be secured from the Ohio Bureau of Motor Vehicles, Columbus.

Following are high spots of the law, taken from a leaflet being distributed by the Bureau in a public education campaign:

Whom Does It Affect?

All motor vehicle owners and operators, including nonresidents, (except vehicles owned by the United States, this State or its political subdivisions, or any municipality therein), when they become involved in an accident in Ohio resulting in death or injury to a person, or property damage to any one person, including yourself, exceeding $100.

What Must You Do After An Accident?

Within 5 days after a motor vehicle accident resulting in injuries or death to any person or damage to any person's property in excess of $100, the operator of **every car involved** must file a written report with the registrar of Motor Vehicles. Official forms may be obtained from any Government subdivision, Police Departments, the Highway Patrol or Deputy Registrars.

You must report the accident **regardless of who is to blame.** If the operator of a car involved is physically incapable of reporting and was not the owner of the car, then the owner must file the necessary report within 5 days. Be smart—get a report form now and keep it in your car. Failure to report an accident, as previously outlined, is punishable by a fine and suspension of your driving license.

Can you Lose Your Motoring Privileges?

Yes—both your driving and registration licenses can be suspended under this law. Within 60 days after receiving a report of an accident that has resulted in injury or death to another person, or damage to the property of another person, exceeding $100, the Registrar of Motor Vehicles must enforce suspension unless he has received satisfactory evidence that you have:

1. Been released from liability; or
2. Been finally adjudicated not to be liable; or
3. Executed a duly acknowledged written agreement providing for the payment of all claims, not exceeding $15,000, resulting from the accident; or
4. Deposited with the Registrar security in an amount sufficient to pay such claims, as determined by the Registrar, not exceeding $15,000.

Remember: Suspension is automatic. It remains in force until one of the above requirements has been met or one year has elapsed without court action for damages being filed. It applies to all cars owned by you. Under certain circumstances you can be required to maintain proof of financial responsibility for the future. The security provisions of the law do not apply, however, if your car was legally parked at the time of the accident or was being operated without your permission.

How Can You Protect Yourself?

The law provides several ways. You must, regardless of any insurance you carry, report an accident in which a person is killed or injured or when property damage exceeds $100. Other provisions of the law do not apply if any of the following conditions are met:

1. To the operator or owner if such owner had in effect at the time of the accident an automobile liability insurance policy with respect to the car involved.
2. To the operator, if not the owner of such motor vehicle, if there was in effect at the time of the accident an automobile liability insurance policy or bond with respect to his operation of motor vehicles not owned by him.
3. To the operator or owner if the liability of such operator or owner for damages resulting from the accident is, in the judgment of the Registrar of Motor Vehicles, covered by any other form of liability insurance policy or bond.

Insurance for resident owners or operators must be written by an insurance company licensed to do business in Ohio and provide the following minimum coverage:

$ 5,000 for property damage,
$ 5,000 for injuries sustained by one person,
$10,000 for all personal injuries resulting from one accident.

Owners of more than 25 cars may qualify as self-insurers. In the case of nonresident owners or operators who are involved in an accident in

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1. Reich, W. J., et al. (1952), A Recent Advance in Estrogen Therapy. II. American J. Obst. & Gynec., 64-174, July

Ohio, adequate insurance written by a company licensed to do business in their state will be accepted. Nonresidents owning or operating motor vehicles in Ohio are subject to all of the provisions and penalties of the Safety Responsibility Law—and, if they do not comply, their driving privileges in the State of Ohio will be withdrawn.

Remember These Points: In order to avoid the security penalties of the law, you must file with the Registrar satisfactory information that you carried adequate insurance at **the time of the accident.** Provision for furnishing such information is included in your accident report.

Visual Loss and Expense Allowance Rulings Adopted by Commission

Two rules of interest to physicians were adopted recently by the State Industrial Commission. One relates to appraisal of loss of visual efficiency. The other has to do with travel expense allowance to claimants who attend medical examinations. Following are the texts of the two rulings:

Appraisal of loss of visual efficiency—Whereas, In order to clarify the proposition of determining visual loss due to injuries received in the course and arising out of employment the following rules are hereby adopted:

(1) In claims involving injuries to the eye resulting in a permanent loss of visual efficiency the Industrial Commission will determine the percentage of visual loss and award compensation in accordance with Section 1465-80, Par. C.

(2) This determination shall not be made until all active symptoms have subsided and no improvement is to be anticipated from additional treatment. All determinations will be made on the basis of the uncorrected loss of visual efficiency.

(3) The percentage of visual loss shall be computed on the basis of percentage loss to the injured eye only. In event the injury involved both eyes the determination shall be on the basis of the weighted method of computation.

(4) The standard method approved by Section on Ophthalmology of the American Medical Association shall be used in the determination of the visual loss.

(5) The loss of the sight of an eye shall entitle claimant to an award of one hundred twenty-five weeks. A visual loss in excess of 80 per cent shall be considered industrial blindness.

(6) The loss of the sight of both eyes shall prima facie constitute permanent and total disability, except the loss of sight of both eyes as result of cataract extraction corrected by ophthalmic lenses shall not constitute permanent total disability.

(7) The permanent partial loss of sight of an eye is computed on the percentage of vision actually lost as result of the injury but in no case shall an award of compensation be made for less than 25 per cent loss of vision.

(8) When it is proven, by acceptable methods of examination, that pre-existing visual loss was present, the percentage loss shall be based only upon the loss incurred as result of the specific injury or occupational disease. (See Rule 10.)

(9) In claims in which there exists no positive evidence of pre-existing visual loss it shall be assumed that visual efficiency was 100 per cent.

(10) The determination of the factors visual efficiency and muscle balance by use of battery testing instruments which have been approved by the Council of Physical Medicine of the American Medical Association will be accepted as competent proof of pre-existing subnormal visual efficiency when such tests are accomplished by a physician experienced in the use of such instrument. These reports should be personally signed by the physician making the test.

(11) Credit is given the American Medical Association for assistance in this matter.

(12) The Form C-18 blank Report of Special Eye Examination is hereby adopted.

Expense allowances—Whereas, economic conditions are such that it becomes necessary to increase the present allowances to Industrial Commission claimants who are required to travel and secure hotel accommodations together with meals while making themselves available for said examinations.

Now therefore be it resolved that claimants be allowed their actual expenses for meals not to exceed $1.00 per meal. Further, said claimants are allowed not to exceed $3.25 per day for hotel accommodations.

Northern Tri-State Meeting At Ann Arbor, April 2

Annual meeting of the Northern Tri-State Postgraduate Medical Association will be held at the Rackham Building, Ann Arbor, Michigan, Thursday, April 2.

An excellent scientific program will be presented, starting at 9:00 A. M. and ending at 5:00 P. M.

Programs will be mailed to all physicians in Northwestern Ohio. Others who may be interested may secure a program and details by writing to Dr. Tom Armstrong, Michigan City, Indiana, secretary of the association.

Federal Trade Commission has issued a new complaint against Chesterfield cigarettes, reaffirming contention that tobacco is a drug, and not a harmless one.



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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

MEDICAL VETERANS OFFER CONSTRUCTIVE PROGRAM

In the January issue, the opinion was expressed that members of the American Medical Veterans Society should offer constructive suggestions and advice on the military problems confronting the medical profession.

A letter from Dr. Kenneth C. McCarthy, Toledo, president of that society, points out that the group is doing just that and that it has established friendly and cooperative relationships with the Council on Emergency Medical Service of the A. M. A. which has these problems in its lap.

Obviously, this is the correct approach. The veterans' society is to be congratulated on its attitude and progress. Following are excerpts from Dr. McCarthy's communication which substantiate his belief that the society is doing a constructive job in offering ways to meet the many problems involved in the present military situation:

"Our Society is pledged to assist in every way the Surgeons-General in procuring adequate medical care for their respective forces. We believe that this will eventually necessitate a re-enactment of the Doctors' Draft Law. We have made a number of suggestions, constructive in intent, to make this law more equitable and more efficient.

"1. We have recommended lower physical standards for medical officers so that any man who is actively practicing civilian medicine can be used in some assignment within his capabilities. This has been adopted by the A. M. A. and put into effect by the Surgeons-General.

"2. We advocate a stricter enforcement of the law so that the lower priorities be completely exhausted before those in the higher categories be called. The A. M. A. is on record in agreement.

"3. We approve, with the A. M. A., of the $100 per month special pay for physicians.

"4. We have asked that physicians who served in Allied Forces be given equal treatment with American medical veterans. A bill to accomplish this has been introduced into Congress.

"5. We have suggested that there be clarification as to the commissioned and professional status of physicians drafted under the law.

"6. We have requested that terminal leave be counted as active duty for recall purposes.

"7. We have asked that the respective services modify their policy as to rank so that recalled reserve officers and newly commissioned civilians might be appointed to grades appropriate to their experience and ability.

"We have assurance from the Armed Forces Medical Policy Council that these suggestions are legitimate and helpful, and will receive consideration when the law is rewritten.

"All members of the Medical Veterans' Society are also members of the American Medical Association. We are sincerely and solely interested in helping the A. M. A. and the Defense Department in their task of supplying the Armed Forces with sufficient medical officers. We are not trying to evade military service. Sixty thousand of us volunteered before, and will again, should need arise."

PROBE OF SOCIAL SECURITY SYSTEM INDICATED

The Federal government loses perhaps as much as $75 million annually in payments to ineligibles kept on state rolls of needy aged, dependent children, blind and the totally disabled, a U. S. Senate investigator told a sub-committee.

The U. S. Chamber of Commerce says the Social Security Act should be revised to give basic old age benefits to all persons past 65; eliminate contributions to states for aged recipients; abandon the "insurance principle" and substitute a pay-as-you-go system.

These are just samples of suggestions being made to take the bugs out of the Social Security System and criticism being hurled at it. At the extremes are found those who want to abolish the whole system and others like the C. I. O. which wants to expand it manyfold.

We like the plan underway to have a full-fledged, honest investigation of the whole thing by the new administration, especially since plans are in the making to raise the F. S. A. to cabinet status. Investigate before you invest, say the Better Business Bureaus.

You might suggest to your Congressman that he suggest the investigation plan.

YOU'LL BE WANTING TO WRITE THESE MEN

Keep these names in mind. You may be wanting to write to them especially from time to time on issues of special importance before the present U. S. Congress:

Senator Robert A. Taft, majority floor leader of the Senate and ranking member of the Senate Committee on Labor and Public Welfare; Senator John W. Bricker, whose proposed amendment to outlaw pacts and treaties which conflict with the U. S. Constitution and laws, is receiving nationwide support; Rep. William H. Ayres, Akron, member of House Committee on Veterans' Affairs; Rep. Robert T. Secrest, Senecaville, member of the same committee.

Rep. William E. Hess, Cincinnati, member of the House Committee on Armed Services; Rep. George H. Bender, Cleveland, and Rep. Clarence J. Brown, Blanchester, members of the House Committee on Government Operations; (Mr.

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Brown also is ranking member of the House Committee on Rules).

Rep. Thomas A. Jenkins, Ironton, ranking member of the House Committee on Ways and Means and author of one of bills providing for private pension plans on a deferred income tax basis, like the Reed-Keogh bills of last session of Congress; Rep. Paul F. Schenck, Dayton, member of the House Committee on Interstate and Foreign Commerce.

All of Ohio's Congressmen hold top-ranking positions in the present Congress because of their terms of service, but those mentioned are in key spots on committees before which legislation of vital interest to the medical profession will be heard.

LESS RIGID SPECIALTY REQUIREMENTS CALLED FOR

The following statement was issued recently by the American Board of Surgery:

"The American Board of Surgery has no objection to those holding its certificate being listed for emergency call service as recognized by the county medical societies throughout the country. The board wishes it made clear, however, that this action only refers to participation in such a service, as, in general, it has always been the board's policy that one who holds this certificate must limit his work to surgery."

Of course the specialty boards know there's a war on in Korea and that doctors are getting scarce in a good many areas, so we suggest they loosen up a bit with their limitations, call service or no call service. When the going gets tough, a physician's specialty should not preclude him from taking care of sick people.

CORONER SYSTEM NEEDS APPRAISAL

Filling the office of county coroner has become a problem in some areas of Ohio.

The law requires that the coroner be a licensed physician. In several counties there were no candidates at the last election. The selection had to be made from write-in candidates. In at least one county, there was no candidate. The job had to be filled by the county commissioners through appointment. Shortly thereafter the physician appointed, resigned, leaving a vacancy.

Obviously, situations of this kind are not good. The office is one of real importance and should be filled by competent men. Local medical societies should take an active interest in seeing that there are well-qualified candidates for the office. Sure, physicians are busy with their own practices, but who isn't busy these days with his personal affairs?

Should this situation become more widespread, there may be a push for changes in the coroner law either to permit laymen to qualify for the office or to abolish the office entirely, substituting some new type of medico-legal investigating system for the present county coroner system. We do not advocate either one of these substitutes at this time but in our opinion something is required to correct bad situations which have arisen and which appear to be multiplying.

DO YOU THINK CODE OF ETHICS SHOULD BE CHANGED?

A. M. A. Council on Constitution and By-Laws is facing the tough and important job of reviewing the Principles of Medical Ethics for the purpose of offering amendments to clarify controversial sections or those which are misunderstood.

Members who have constructive suggestions should transmit them to Dr. George F. Lull, secretary of the A. M. A., who will relay them to The Council.

Here's a chance for any member who has an idea for improvement in this basic law of the organization to have his say.

DIRECTOR OF HEALTH'S SALARY SHOULD BE INCREASED

The present Ohio General Assembly will be asked to increase the salary of the office of State Director of Health, now $8,600 by statute.

When the great responsibilities of that office and the qualifications required of the physician holding it are taken into consideration it becomes quite evident that the present salary is entirely inadequate. In fact, under existing civil service laws, employees of many of the state departments receive more than the appointive heads of the departments.

Obviously, such a situation is not good and should be corrected. There would be no better time to do the job than in 1953.

GIVE YOUR HELP TO THE CHRONIC DISEASE SURVEY

The Chronic Disease Division of the State Department of Health has started a statewide study of facilities and services available for the chronically ill. A uniform questionnaire has been designed to collect necessary data. The survey will be spearheaded by local health departments.

Obviously, physicians will have much to contribute to this desirable project. If and when, you are called upon for information, cooperate to the best of your time and ability. Before solutions can be found for the problems of chronic illness, basic facts must be assembled and analyzed. The medical profession can, and should, play an important role in this much-needed and long-overdue study of the situation here in Ohio.

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Cleveland's Medical Civil Defense Program Is Rated "Tops"

According to an article appearing in a recent issue of the *Cleveland Press*, Greater Cleveland has "one of the nation's most advanced civil defense medical programs . . ."

The following facts are abstracted from the newspaper account of a report issued by Mrs. Kathryn Gasker, executive secretary of the Disaster and Relief Committee, regarding the accomplishments of the medical people:

Ninety-five per cent of the doctors in Cuyahoga County—or 1,665—have registered for disaster assignments through the Cleveland Academy of Medicine.

Most physicians have been signed primary and secondary disaster posts.

A total of 2,500 nurses have been classified for the program by District 4 of the Ohio State Nurses Association.

Eight hundred dentists have registered through the Cleveland Dental Association and the Dental School of Western Reserve University is teaching advanced first aid to provide trained personnel for emergency teams.

Four hundred pharmacists have volunteered for assignment to medical teams through the Northern Ohio Druggists Association. Dr. Thomas D. Kinney of City Hospital heads a course in laboratory techniques for these pharmacists.

Cuyahoga County Druggists have offered their own stocks and supplies for use in an emergency.

Three hundred morticians, registered through the Cuyahoga Funeral Directors Association are being organized into identification and embalming teams under the direction of Dr. Samuel R. Gerber, county coroner.

A feeding manual has been prepared by the Cleveland Dietetics Association. Among other items, plans are being made for feeding infants in the event of bomb damage.

Hospitals, schools, industrial clinics and churches which would be used as emergency treatment centers have been designated in most localities.

1952 Birth Rate Hits "Unexpected" High Level

More babies were born in the United States during 1952 than in any previous year in the nation's history, Metropolitan Life Insurance Company statisticians reported. The total is estimated at 3,875,000, and the year's birth rate was approximately 25 per 1,000 population.

The maintenance of the birth rate at the current high level is described by the statisticians as "rather unexpected," in view of a decline since 1946 in the marriage rate.

"Last year's record reflects a large number of second, third and fourth children born of post-World War II marriages," the statisticians comment. "This is to some extent the result of the relatively low age at marriage in recent years, and also may be considered as indicating a change in attitude as to the size of the family."

Suit Against Hospital Dismissed

Suit of Dr. C. E. Bolinger, Marysville, against the Board of Trustees of the Union County Memorial Hospital has been dismissed in Common Pleas Court following a hearing on a demurrer filed by the board. Dr. Bolinger asked that the board be enjoined from preventing him from practicing major surgery in the hospital.

The court upheld the contention of counsel for the hospital that a certificate to practice medicine and surgery issued by the state does not necessarily confer upon the holder of the license the right to practice major surgery in the Union County Memorial Hospital. It was pointed out in the decision that Ohio statutes grant the hospital board the right to make whatever requirements it deems expedient for the government of the hospital and to maintain the standards of the institution. The contention of the board that all physicians practicing major surgery in the hospital should be required to comply with the standards and qualifications set by the hospital for the performance of major surgery therein was sustained by the court.

If you are moving to a new location or for other reason plan to change your address, please notify the Headquarters Office as early as possible so that your copy of *The Journal* and other mail may be sent to you without delay.

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79 East State Street,
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Frances E. Walsh, Springfield
Alice Shoppe, Steubenville
Crooks & Coleman Corset Shop, Toledo
Davis Dry Goods Co., Toledo
Lamson Bros. Co., Toledo
Kaser's, Wooster
Mary Bennett Corset Shoppe, Zanesville

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

A committee appointed by A. M. A.'s Board of Trustees spent 45 minutes with President Eisenhower in a "get acquainted" meeting and general discussion of health problems. A. M. A. President Louis H. Bauer said the White House conversations were friendly and helpful although "merely exploratory." Also the committee conferred with Mrs. Oveta Culp Hobby, Federal Security Administrator, and Surgeon General Leonard A. Scheele of the U. S. Public Health Service. Members of the delegation commented on the friendly reception from Mrs. Hobby and said several health problems were discussed.

* * *

Two million cubic centimeters of gamma globulin turned over to the Red Cross by the Armed Forces Medical Policy Council from military stockpiles will bring the civilian supply for paralytic polio to 6,540,000 cc., about enough for a million average doses. Use will be limited strictly to epidemic areas.

* * *

Reporting to Congress, the Atomic Energy Commission reassures that thorough tests following the 20 explosions of atomic bombs in Nevada show that there is no threat to public health even in the vicinity of the test area.

* * *

Public Health Service says preliminary data shows about 600,000 persons were under supervision of state or county mental hospitals at the end of 1950 as compared with about 580,000 the previous year.

* * *

A "Little Hoover Commission" to advise President Eisenhower on reorganization of government is now official. Nelson Rockefeller of New York City is chairman. The other members are Milton Eisenhower, president of Pennsylvania State College and Arthur S. Flemming, president of Ohio Wesleyan University and a member of the original Hoover Commission.

* * *

A recent referendum shows that members of the U. S. Chamber of Commerce favor the following revisions in the Federal social security system: (1) Give basic Old Age and Survivors benefits to all persons past 65; (2) bring all working persons under OSAI coverage and subject to payments out of income or earnings; (3) eliminate U. S. contributions to states for aged relief recipients, all of whom would be blanketed under OSAI; (4) abandon the "insurance principle" of social security and substitute a pay-as-you-go system, "thereby establishing a direct relation between income and outgo."

* * *

At the close of 1952, Hill-Burton Hospital construction reached a total of 1,980 projects, 1,106 of which were completed. Aggregate estimated cost was $1,558,312,039, one-third of which was Federal money. Ohio stood second in amount spent and number of beds ($85 million and 4,757 beds). Texas received the most.

* * *

Mrs. Oveta Culp Hobby, Oscar Ewing's successor as Federal Security Administrator, is being invited to attend cabinet meetings.

* * *

Dr. William A. Sawyer resigned recently after serving since 1919 as medical director of Eastman Kodak Company. He will serve as medical and health consultant to the International Association of Machinists which has announced plans for sponsoring prepaid health insurance plans in its local unions.

* * *

Senator William A. Purtell, (R Conn.), was named chairman of the Senate Labor subcommittee on health legislation. Serving with him are two other Republican freshmen, Griswold of Nebraska and Goldwater of Arizona. Democrats are Hill of Alabama and Lehman of New York.

* * *

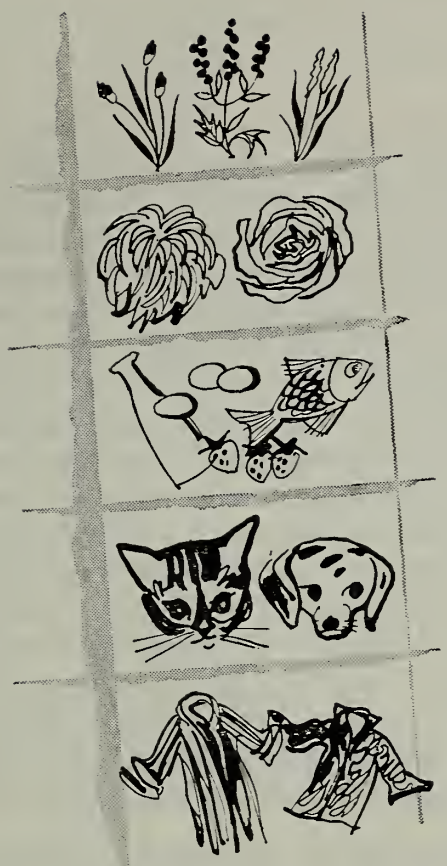
Average daily patient load in V. A. hospitals during the past fiscal year was 105,110. The year's admissions totaled 495,056 and discharges, 490,163.

* * *

Dr. M. G. Candau, a Brazilian educated in Rio de Janerio and at Johns Hopkins, has been nominated as director general of the World Health Organization to succeed Dr. Brock Chisholm. His selection is subject to confirmation by the Sixth World Health Assembly, in Geneva, May 5.

* * *

The annual meeting of the National Health Council in New York, March 18-20 will feature a two-day forum centering on recommendations of the "Magnuson Commission" which was established by Mr. Truman, according to an announcement from Mrs. Oswald B. Lord, president.



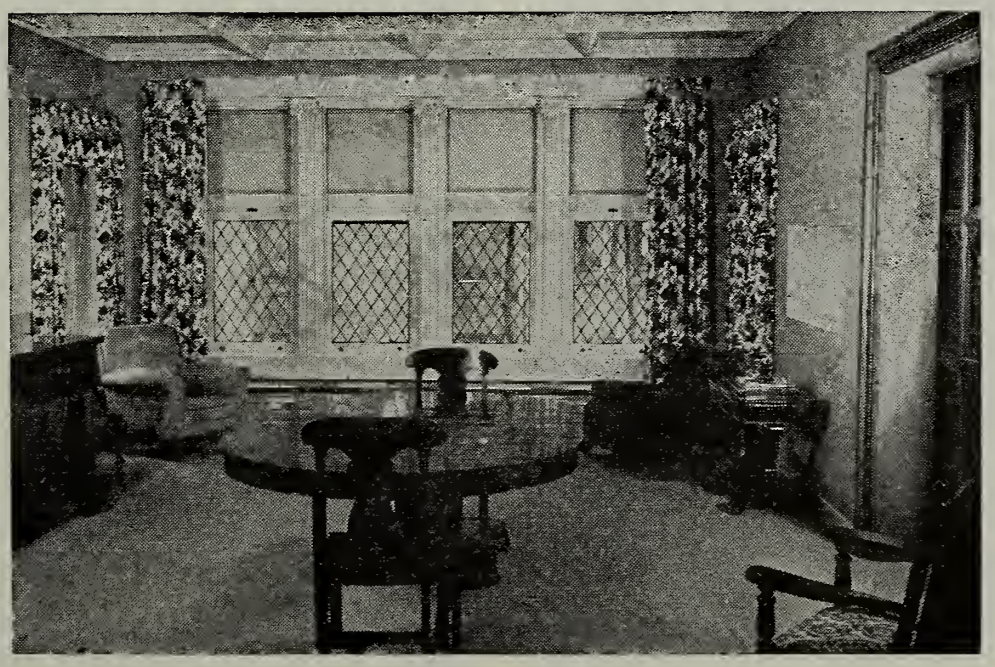
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In Memoriam . . .

Floyd F. Ayres, M. D., Akron; Chicago College of Medicine and Surgery, 1909; aged 68; died February 6; former member of the Ohio State Medical Association. After practicing in Brunswick and Hinckley in Medina County, Dr. Ayres moved to Akron in the early 1930's. Two brothers and a half-sister survive.

Roderick E. Brady, M. D., Cleveland; University of Toronto Faculty of Medicine, 1911; aged 66; died January 18. Dr. Brady had been a practicing physician in Cleveland since 1917. He was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow and three daughters.

Frederick Fischl, M. D., Toledo; medical degree from University of Vienna, Austria, 1911; aged 67; died January 15; member of the Ohio State Medical Association; member of the American Medical Association; member of the American Academy of Dermatology and Syphilology. A native of Bohemia, Dr. Fischl came to this country first in 1929 to lecture at Columbia University and other colleges, later returning to Europe. In 1939 he established permanent practice in Toledo. Surviving are his widow and a sister.

Henry Lee Good, M. D., Hamilton; Pulte Medical College, Cincinnati, 1907; aged 72; died January 21; former member of the Ohio State Medical Association through 1947. A native of Hamilton, Dr. Good served all of his professional career there. In addition to his medical practice, he was interested in a number of community affairs, among which were the Y. M. C. A. and the Boy Scouts. Affiliations included memberships in the Rotary Club, The Elks Lodge, the Butler County Country Club, the Presbyterian Church, several Masonic orders and the Ohio State Archaeological and Historical Society.

William H. Guiss, M. D., Tiro; Western Reserve University School of Medicine, 1887; aged 88; died January 21; member of the Ohio State Medical Association through 1951. A practicing physician in Tiro for a lifetime, Dr. Guiss had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He had gone into semi-retirement about 15 years ago. Interests in community affairs were many. He had served on the Tiro Board of Education and the Crawford County Board of Education and had been on the Tiro Village Council for 52 years. He also was interested in several business and agricultural enterprises in the community. Affiliations included memberships in the Lutheran Church, and the Knights of Pythias. A daughter, a sister and a brother survive.

Oscar P. Klotz, M. D., Findlay, Illinois Medical College, 1905; aged 77; died January 22; member of the Ohio State Medical Association through 1951; former member of the American Medical Association; member of the Northern Tri-State Medical Association; vice-president of the Hancock County Medical Society, 1925, and its president, 1926-1928. Dr. Klotz was a member of The Council of the State Association, representing the Third District, from 1928 to 1940, inclusive. He had been a practicing physician in Findlay since 1920, and in addition to his professional work and activities in organized medicine, he was interested in numerous community affairs. He was a thirty-second degree Mason, a member of the Elks Lodge, a member and past-president of the local Kiwanis Club, and was active in the Methodist Church. Surviving are his widow, a daughter and two sisters.

Hanson H. Marsh, M. D., Seven Mile; Medical College of Ohio, Cincinnati, 1903; aged 77; died January 15; former member of the Ohio State Medical Association. Dr. Marsh had served all of his professional career in Butler County. He had retired as president of the County Board of Health last year after many years in that capacity. Other interests in the community included activity in the Methodist Church. A son survives.

Horace Dwight McCulloch, M. D., Toronto (Ohio); Ohio Medical University, Columbus, 1906; aged 83; died January 20; former member of the Ohio State Medical Association, through 1949; delegate of the Jefferson County Medical Society in 1918. Dr. McCulloch had served all of his professional career in Toronto, where he also was active in many community affairs. Affiliations included memberships in several Masonic orders, the Kiwanis Club, the local Underprivileged Child Committee, and the Presbyterian Church. His widow survives.

Lewis T. Mitchell, M. D., Lorain; University of the South Medical Department, Sewanee, Tenn., 1898; aged 76; died January 25; former member of the Ohio State Medical Association, through 1948. Dr. Mitchell had resided for about eight years in Lorain where prior to his retirement he was physician for the National Tube Company. He formerly had practiced in Bedford, and before that was for 24 years in Blawnox, Pa. He was a veteran of World War I, and was a member of the Methodist Church. Surviving are his widow, a son and a daughter.

Oscar C. Ralston, M. D., Marion; Eclectic Medical College, Cincinnati, 1892; aged 81; died Feb-

ruary 8. Dr. Ralston had practiced in Columbus, Springfield, and Bellefontaine as well as in Marion. Surviving are two daughters, a son, a sister and a brother.

Francis E. Reed, M. D., Huron; Ohio Medical University, Columbus, 1905; aged 74; died February 6; member of the Ohio State Medical Association and member of the American Medical Association; vice-president of the Erie County Medical Society, 1940. Dr. Reed had been a practicing physician in Erie County since 1922. He was surgeon for the Wheeling and Lake Erie and Nickel Plate Railroads, and for 20 years served on the Erie County Board of Health. He also served on the Huron Board of Education. Affiliations included the American Legion, the Grange, the Rotary Club and the Masonic Lodge. His widow and a daughter survive.

William S. Rhodes, M. D., Columbus; Starling Medical College, Columbus, 1898; aged 75; died January 16; former member of the Ohio State Medical Association. Dr. Rhodes had practiced in Glouster and Nelsonville before moving to Columbus in 1929. He had retired about four years ago. The Columbus Academy of Medicine honored him a few years ago with the 50-Year Pin and Certificate of the Ohio State Medical Association. Affiliations included memberships in the Methodist Church, several Masonic orders and the American Legion. Surviving are his widow and a son, Dr. William M. Rhodes, also of Columbus.

Bertha E. Hunt Shaffer, M. D., Youngstown; Ohio Medical University, 1898; aged 84; died January 3. Dr. Shaffer was the wife of the late Dr. John H. Shaffer and had been associated with him in the practice of medicine for a few years after their marriage.

Stanley J. Spotanski, M. D., Cleveland; Western Reserve University School of Medicine, 1915; aged 65; died January 15. Dr. Spotanski had been a practicing physician in Cleveland for about 40 years. A native of the United States, he was a member of the Alliance of Poles and the Union of Poles. Surviving are his widow, a son and a daughter.

William A. Stoutenborough, M. D., Columbus; Eclectic Medical College, Cincinnati, 1913; aged 66; died January 19; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Ophthalmology; member of the American Academy of Ophthalmology and Oto-Laryngology. Dr. Stoutenborough moved his practice from Mechanicsburgh to Columbus about 25 years ago. Affiliations included memberships in the Community Church, the Masonic Lodge and the Optimist Club. Surviving are his widow, a daughter, two brothers, and two sisters.

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Law on Prescription Drugs . . .

Details of New Federal Statute Enumerated by Director of U. S. Food and Drug Administration; How Physician Can Help Pharmacist Explained

OHIO physicians should read carefully the following communication by Dr. Irvin Kerlan, acting medical director of the Food and Drug Administration, Washington, D. C.

It relates to provisions of the new Federal Law governing the prescribing of drugs and the sale of drugs over the counter. Special emphasis is given to the provisions relating to refilling of prescriptions.

The communication, which was addressed to the editor of *The Journal of the A. M. A.* and published in the February 13 issue of that journal, reads as follows:

* * *

We feel it would be helpful to outline in some detail the effect on the physician-pharmacist-patient relationship brought about by the Durham-Humphrey amendment to the Federal Food, Drug, and Cosmetic Act that became effective April 26, 1952. From the tenor of many articles in pharmacy trade journals and from the correspondence we receive from practicing pharmacists, it is apparent that physicians generally are not fully informed about this new law and the responsibilities it places on the pharmacist.

PRESCRIPTION REQUIRED

This amendment, Public Law 215, provides a statutory definition of certain types of drugs that may be sold by the pharmacist only on the prescription of a "practitioner licensed by law to administer such drugs." It further provides that prescriptions for these drugs cannot be refilled except on the authorization of the prescribing physician. The prescription or the refill authorization may be either written or oral (for example, telephoned). If the order is oral the pharmacist is required to make a written record and file it.

It should be borne in mind that the statutory definition of prescription drugs embraces not alone those that are directly dangerous. The three categories of prescription drugs defined in the amendment are: (1) certain hypnotic or habit-forming drugs specifically named in the law and their derivatives; (2) a drug that is not safe for lay use "because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use"; and (3) a "new drug" that has not been shown to be safe for indiscriminate lay use. Prescription drugs must be labeled by their distributors with the legend "Caution: Federal law prohibits dispensing without prescription."

RE-FILL PROBLEMS

We believe there has been little difficulty insofar as the original prescription is concerned. Confusion has arisen over the requirement that refills must be authorized by the prescriber. We are informed that many physicians do not indicate on the original prescription whether it may be refilled and that these physicians are sometimes quite irritated when called about authorization to refill. Pharmacists feel that they are caught in the middle and are losing the good will of the physician and the patient in trying to comply with the clear terms of the law.

A great deal of annoyance and misunderstanding can be avoided and compliance with the law facilitated if the physician at the time of writing or telephoning the original prescription would include instructions about refilling. The physician can authorize as many refills or refilling for as long a time as his professional judgment indicates before he sees his patient again. Prescription blanks that make it convenient for the physician to give such instructions are now widely available.

ABUSES CITED

We would like to add a brief comment about the use of refill instructions such as "ad lib," "as requested," or "PRN." We have investigated cases in which prescriptions for hypnotics such as the barbiturates, or central nervous system stimulants such as the amphetamines, were being refilled many years after they were written, on an almost daily basis. Obviously, the drugs in these cases were not being supplied in accordance with the will and purpose of the physician who wrote the original prescription. Nevertheless, if the refill instruction on the original prescription was of the indefinite and continuing type referred to above, correction of abuses is complicated and difficult. We might also emphasize that the pharmacist has the responsibility under the law to accept an order for a prescription drug only if it comes from a "practitioner licensed by law." We recognize that as a practical matter the physician's office nurse or secretary will in many cases telephone the prescriptions, but it is the pharmacist's responsibility to make certain that the order is bona fide. Of course, nothing in the Food, Drug, and Cosmetic Act in any way modifies the law and regulations relating to prescriptions for narcotics.



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SCHERING

Activities of County Societies . . .

GUERNSEY

The following officers and delegates were elected by members of the Guernsey County Medical Society for the year: Dr. Howard Van Noate, president; Dr. J. A. Toland, vice-president; Dr. Reo M. Swan, secretary-treasurer; Dr. J. A. Toland, delegate, and Dr. O. R. Martin, alternate delegate.

At the December 4 meeting, Dr. F. Gordon Lawyer discussed "X-Ray Diagnosis." Dr. Floyd R. Town was received as a new member.

On December 18, the Ladies Night program was held in the dining room of the Berwick Hotel, Cambridge. Readings, instrumental music, games and polaroid pictures contributed to an evening of entertainment.

The scientific discussion for the January 8 meeting was in charge of Dr. F. Gordon Lawyer, Cambridge, who spoke on "Recent Advances in Skin Diseases." It was announced that Dr. E. A. Carlin had moved from Senecaville to Newark. Dr. Henry Wells has resigned from the Guernsey County Health Board and Dr. Robert Ringer has been appointed to that board.

The Councilor, Dr. Robert S. Martin, Zanesville, Eighth Councilor District, visited the Guernsey County Medical Society meeting on February 5. He made some welcome suggestions in how to approach county commissioners regarding their responsibilities and obligations for the aged after they have used the Aid for the Aged $200 special medical allowance.

Dr. M. C. McCuskey, Cambridge, presented the scientific discussion with the subject, "Recent Trends in Orthopedic Surgery. It was well presented and received.—Reo M. Swan, M. D., Secty.-Treas.

MAHONING

Cooperation and high professional standards were stressed by the past and present presidents of the Mahoning County Medical Society at the annual banquet on January 15 attended by 140 physicians at the Youngstown Country Club.

MIAMI

Dr. Lewis Owens, associate professor of medicine, University of Cincinnati College of Medicine, spoke on the subject, "Common Problems of Diabetes in General Practice," at the February 6 meeting of the Miami County Medical Society.

MONTGOMERY

"The Business Side of Medical Practice," was discussed at the January 9 meeting of the Montgomery County Medical Society in Dayton by Mr. Rollen Waterson, executive secretary of the Alameda County (California) Medical Society.

SHELBY

Dr. Delphis Russell Milliette, of Anna, was honored at the joint meeting of the Shelby and Miami County Medical Societies in Piqua on January 8, by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association.

Dr. Milliette has served all of his professional career in Shelby County and in addition has served on the Anna school board of the Shelby County School.

Presentation was made by Dr. Merrill D. Prugh, Dayton, Councillor of the Second District of the Ohio State Medical Association.

SUMMIT

At the February 3 meeting of the Summit County Medical Society in Akron, Dr. Philip Thorek, clinical associate professor of surgery, University of Illinois, spoke on the subject, "The Acute Abdomen."

TRUMBULL

The Trumbull County Medical Society held its first meeting of the year on January 21 at the Trumbull Country Club. The meeting was presided over by the new president, Dr. E. R. Westbrook. Guest speaker for the evening was Dr. C. R. Hartsock, who is on the medical staff of the Cleveland Clinic and who gave an interesting talk on "Symptom Syndrome's Association with Fluid Retention."—G. A. Sudimack, M. D., Secty.-Treas.

TUSCARAWAS

The Tuscarawas County Medical Society met on January 15 at the Boulevard Medical Building, with Dr. Benjamin Pilloff presiding.

Dr. R. J. Foster, chairman of the Public Relations Committee, reported that his committee had met with Mr. Clarence Miller, welfare director for Tuscarawas County, to discuss medical and surgical fees for the care of indigent patients receiving support from the County Welfare Department. The Society adopted the Committee's recommendation that the fees be revised upward and that the schedule for dependents as submitted by the Bankers Life & Casualty Company and printed in its fee schedule be adopted. In addition, fees for surgeons' assistants were set at 20 per cent of the surgeon's fee, and anesthesia is to be charged at the rate of $10 for the first hour and $5 for each additional hour, with a maximum fee not to exceed 20 per cent of the surgeon's fee.

The Society authorized the purchase of a screen to supplement the gift of a movie projector by Dr. S. H. Winston.

Speaker of the evening, Dr. George S. Hackett,

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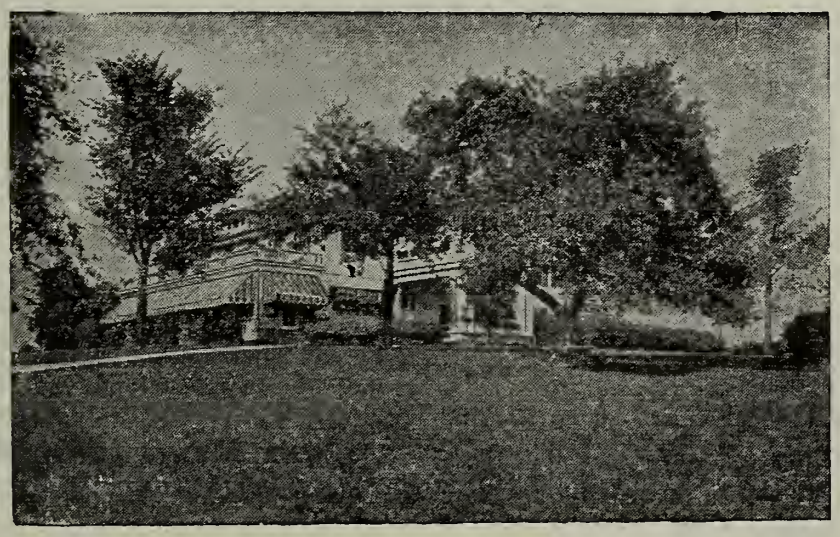
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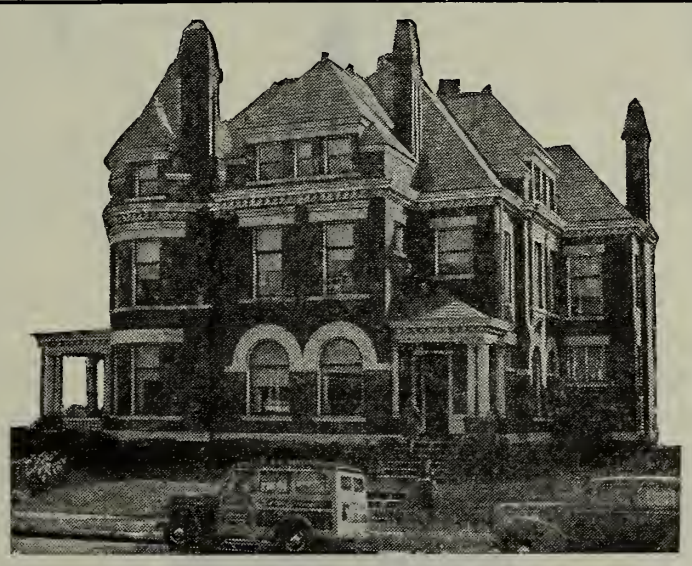
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of Canton, was introduced by Dr. Max Shaweker. He described a method of diagnosing and treating the sacroiliac condition frequently encountered. He described a method of producing fixation by a series of injections of a sclerosing solution.

Toxoplasma Serologic Test Service Is Available

Reference diagnostic service for toxoplasmosis is available at the Communicable Disease Center Laboratories through the Ohio Department of Health, Dr. John D. Porterfield, director of the Department, reported. At present, the Sabin-Feldman methylene blue dye tests is being performed, and in the future the complement fixation test will be provided for checking certain sera.

Practicing physicians are to submit blood specimens to the Ohio Department of Health Laboratory, in accordance with established policies relative to reference diagnostic services at the Communicable Disease Center. Each specimen should be accompanied by a completed form. Supplies of this form are available upon request from the Ohio Department of Health Laboratory, W. 10th Ave., Columbus 10.

Whole blood specimens should be submitted. No preservative should be added, but sterile technics should be employed to prevent contamination.

At present, until more information is available, the Communicable Disease Center will be appreciative if requests are restricted to suspected cases of congenital toxoplasmosis. Whenever possible, blood from both mother and infant should be submitted.

A positive diagnosis of congenital toxoplasmosis can be made when the dye-test titer is 1:256 or more in both the mother and child, provided the child is over four months of age. When a high titer is obtained in a child during the first weeks of life, the test should be repeated at the end of four months in order to reveal a possible passive transfer of antibody from the mother.

Congress of Physical Medicine Will Meet in Chicago

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 31-September 4, at the Palmer House, Chicago. Sessions are open to physicians in good standing with the American Medical Association and to therapists who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained from the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2.

Cook County Graduate School of Medicine

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, two weeks, starting March 16, March 30, April 13. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting June 1. Surgical Anatomy & Clinical Surgery, two weeks, starting March 16, June 15. Basic Principles in General Surgery, two weeks, starting March 30. Gallbladder Surgery, ten hours, starting April 20. Surgery of Colon & Rectum, one week, starting April 13. General Surgery, one week, starting May 4. General Surgery, two weeks, starting April 20. Fractures & Traumatic Surgery, two weeks, starting June 15.

GYNECOLOGY—Intensive Course, two weeks, starting March 16. Vaginal Approach to Pelvic Surgery, one week, starting March 30.

OBSTETRICS—Intensive Course, two weeks, starting March 30.

PEDIATRICS—Intensive Course, two weeks, starting April 6. Congenital Heart Disease, two weeks, starting May 18.

MEDICINE—Intensive General Course, two weeks, starting May 4. Electrocardiography & Heart Disease, two weeks, starting March 16. Allergy, one month and six months, by appointment.

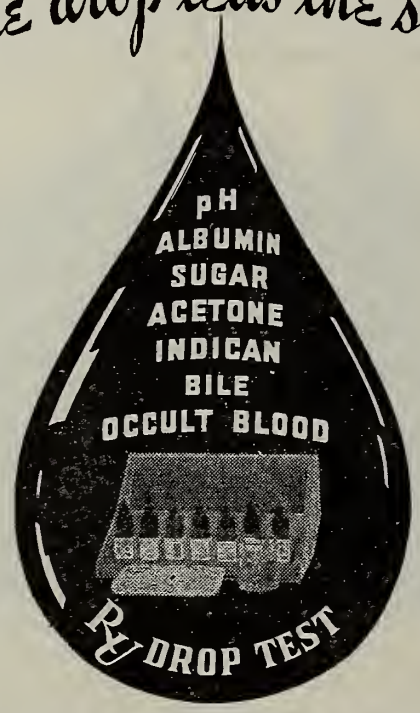
UROLOGY—Intensive Course, two weeks, starting April 13. Ten-Day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY — Intensive Course, two weeks, starting May 11.

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Contributions for the American Medical Education Foundation have been received from the following additional counties: Mahoning, Allen, Clark, Morrow, Hardin, Clinton, Richland, Union, Washington and Hamilton.

STATE BOARD MEETING

Mrs. Paul Woodward, president, conducted a meeting of the State Board on January 21 at the Columbus Athletic Club. Dr. Harve Clodfelter, Columbus, President of the Ohio State Medical Association, was the guest speaker at the luncheon preceding the meeting.

NOMINATING COMMITTEE

The State Nominating Committee, composed of a representative from each of the eleven districts, met in Columbus on January 22. Mrs. W. R. Gibson was named chairman of the committee.

MEDINA COUNTY RE-ACTIVATED

Medina County Auxiliary has revived its Constitution and has become an active unit of the State Auxiliary.

* * *

ALLEN

Mrs. J. M. McBride was hostess to members of Allen County Auxiliary on Jan. 27. The morning was devoted to making washable slippers for patients in Memorial, St. Rita's, the District Tuberculosis and Bluffton Community hospitals. At the business meeting following luncheon, plans were made for the annual benefit card party to be held on Feb. 24.

AUGLAIZE

Auglaize County Medical Society and the Auxiliary met at the home of Dr. and Mrs. R. H. Schaefers on Jan. 18 for the annual covered-dish dinner. Games were enjoyed throughout the evening.

BUTLER

Members of the Butler County Auxiliary entertained their husbands at a dinner-dance on Jan. 28 at the Hamilton City Club. Mrs. George Riggs was chairman of arrangements.

Senior high school Y-Teens of the Y. W. C. A. conducted a nursing conference in Hamilton High School auditorium on Feb. 4 for all girls of Hamilton High School and girls in grades 10, 11 and 12 at Notre Dame High School. Representatives from fifteen nursing schools of the area attended. Special speaker was Mrs. Edwin A. Buescher, representing the committee of nurse recruitment of the State Auxiliary. Adult committee members assisting with arrangements for the conference included Mrs. G. E. Marr, president of Butler County Auxiliary.

CHAMPAIGN

A luncheon meeting of Champaign County Auxiliary was held at Mercy Hospital on Feb. 2. At the business meeting conducted by Mrs. F. R. Grogan, president, Mrs. F. E. Lowry was appointed delegate to the state convention.

DELAWARE

Delaware County Auxiliary met at the home of Mrs. E. J. Steele on Jan. 13. Mrs. George Blydenburgh reported on the extensive plans which have been made for the February heart fund drive sponsored by the Auxiliary. Mrs. George J. Parker gave a report on the progress of the Student Nurses' Loan Fund committee.

ERIE

The personnel of Good Samaritan and Providence Hospitals were entertained by Erie County Auxiliary in December. Mrs. H. F. Kesinger was chairman of the annual Christmas tea held in the doctors' lounge of Good Samaritan Hospital on Dec. 8. Mrs. William F. Burger served as chairman for the tea held at Providence Hospital on Dec. 9.

The fifth and final in a series of nurse recruiting programs was held Dec. 3 at Margaretta school. Thirty-four high school girls heard a talk by Miss Jeanne Stack, R. N., from the Providence Hospital School of Nursing. Student nurse, Miss Mary Mantey, accompanied her. Three Toledo hospitals—Maumee Valley, Flower and Toledo—were represented and presented a film "Keepers of the Lamp." From Cleveland the Frances Payne Bolton Hospital was represented by a collegiate student nurse; City Hospital by a diploma student nurse; and John Adams Vocational High School by a practical nurse. Chairman of this nurse recruitment project is Mrs. Lester G. Parker.

Miss Helen Brouwer, physiotherapist at Good Samaritan Hospital, was speaker at the Jan. 5 meeting held in the Business Women's Club residence. Dr. R. Berneta Block briefly discussed the health department projects.

Erie County Auxiliary held a luncheon meet-

ing at the Business Women's Club on Feb. 2. Four high school students presented a program relative to the establishment of a mental health clinic in Erie County.

Commencing Feb. 3 and continuing each Tuesday morning for a period of four months, the Nancy Lake program, "Especially for You," will be sponsored by the Auxiliary and will present the health services available to Sandusky and Erie County residents. "Your Hospital Story," a group of six programs prepared by Good Samaritan and Providence Hospitals, will inaugurate the series. The second group of programs will be devoted to the services provided by the Erie County health department; and a third group, to include all special services, will conclude the series.

FAIRFIELD

The annual Christmas party of the Woman's Auxiliary and the Fairfield County Medical Society was held on Dec. 11 at the Lancaster Country Club. Bridge, canasta and group singing followed the dinner.

At the Jan. 12 meeting held at the Hotel Lancaster, plans were discussed for the party for the County Home. Mrs. A. M. Kelley will serve as chairman. Mrs. Fred Spangler was appointed chairman of the Nurse Recruitment tea to be held in March.

FRANKLIN

A Guest Day meeting of the Woman's Auxiliary to the Columbus Academy of Medicine was held at the Gallery of Fine Arts on Jan. 19. Mrs. E. G. Marsh, director of the tenth district, members of Auxiliaries in that district, wives of interns and residents, and guests of individual members were invited to attend. Mrs. Gilman Kirk and Mrs. Carr Dix were in charge of the program which included character sketches by Edwan A. Wright, director of drama at Denison University. Mrs. L. W. Cellio served as tea chairman.

GREENE

Plans for a public relations meeting at Central High School on March 10 under the auspices of the Greene County Auxiliary were discussed at the Jan. 6 meeting held at the home of Mrs. Mary Little Dice. It was voted to contribute $25.00 to the American Medical Education Foundation. Plans were made for the observance of April as Nurse Recruitment Month, prior to the selection of high school girls for nursing scholarships.

Miss Ruth Dennis, Greene County district librarian, reviewed Dr. James Pepper Fisher's book, "A Few Buttons Missing."

GUERNSEY

Guernsey County Auxiliary entertained at a "Careers for Nursing Party" in the parlors of

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First Methodist Church on Jan. 28. More than 75 high school pupils attended, while additional guests included nurses and nurses' aides from the Cambridge area and teachers who accompanied the pupils. Mrs. Elva Evans, executive secretary of the Cleveland Council for Community Nursing, was the principal speaker. Miss Evelyn Hanneman of Central School of Practical Nursing, Cleveland; Miss Betty Evans, St. Alexis Hospital School of Nursing; and Mrs. Betty Finlayson, Francis Payne Bolton School of Nursing at Western Reserve University, each representing a different type of training, joined Mrs. Evans in an informal discusison of entrance requirements, costs, lengths of training and types of certification of various schools.

HAMILTON

Hamilton County Auxiliary met on Jan. 20 in Vincent Hall, the nurses' residence of Children's Hospital. A social hour, with Mrs. Samuel L. Bauer serving as hospitality chairman, preceded the business meeting conducted by Mrs. William H. Lippert. Mrs. Richard D. Bryant, program chairman, introduced Mr. Edward Heyd, administrator of the hospital, who spoke on "Making Sense Out of the Hospital Dollar."

KNOX

Knox County Auxiliary met at the home of Mrs. Henry Lapp on Dec. 10. Mrs. Lenore Black, chief nurse of the local medical organization for civil defense, spoke and distributed civil defense pamphlets.

Knox County Medical Society entertained the Auxiliary at a dinner-dance at the Homestead club rooms on Dec. 16.

Knox County Auxiliary met at the home of Mrs. George Imhoff on Jan. 28. Reports were given by the three delegates to the Family Life Institute held in November. It was voted to contribute to the Tuberculosis and Infantile Paralysis funds. Mrs. Robert Eastman reviewed the book, "A Man Called Peter."

LICKING

The second annual Christmas dinner party of the Licking County Auxiliary and Medical Society was held on Dec. 11 at the Moundbuilders Country Club. After dinner, the group was entertained by a singing quintet. The doctors' Glee Club sang several selections, and Leo Howarth, pianist, accompanied group singing.

Members of the Licking County Auxiliary met for dinner on Jan. 27 at the Hotel Warden. Mrs. J. K. Pease, associate director of the Ohio State School of Nursing, presented views with regard to the selection of candidates for nursing scholarships.

LORAIN

Mrs. Jean Cooley, chief physiotherapist at Veterans Hospital, Cleveland, gave an interesting sketch of her work with the physically and men-

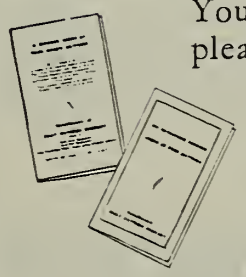


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tally ill veterans at the December meeting of Lorain County Auxiliary.

The January luncheon meeting was held at Castle-on-the-Lake. Miss Etta A. Creech, director of Central School of Practical Nursing in Cleveland, described the activities of this training center. At the business meeting, it was voted to provide recreational equipment for Elyria Memorial Hospital. The annual contribution was sent to Pleasant View Sanatorium.

LUCAS

Mrs. Myron Means, president of the Lucas County Auxiliary, conducted a Board meeting on Jan. 7.

A progressive tea for captains and lieutenants of the Mothers' March on Polio was held on Jan. 6 at the Academy Building.

A joint meeting of the afternoon and evening Live Issues Study Groups was held on Jan. 9 at the home of Mrs. E. J. Singer. Marshall Lipman spoke on "Can We Destroy Communism?"

A luncheon meeting of Lucas County Auxiliary was held at the Academy Building on January 20. Mrs. James R. McAuley served as chairman and introduced the speaker, Mrs. John C. Taylor, whose topic was "Volunteer Work in Toledo."

The Mental Hygiene Study Group met on Jan. 27 at the Mental Hygiene Center. Mr. Frank Bean discussed "Problems of the Adolescent." The Live Issues afternoon group met on Feb. 4 at the home of Mrs. David M. Katchka. The evening group met with Mrs. Boni Petcoff on Feb. 6. The topic for discussion at both meetings was "Personalities in the Eisenhower Administration."

The annual Academy-Auxiliary dinner dance was held at the Commodore Perry Hotel on Jan. 24. The theme "South of the Border" was carried out in the music, decorations and entertainment.

In cooperation with the Red Cross, the public relations and civil defense chairmen have planned a program of classes to be offered Auxiliary members and their friends. These include courses in Canteen Service, Home Nursing, First Aid, and Advanced First Aid.

MAHONING

Mahoning County Auxiliary met at the Tod Nurses' Home on Jan. 20. During the semi-annual business meeting, detailed reports of committee activities were given. Plans were completed for the annual spring style show and tea to be held on Feb. 17, with Mrs. Harold Chevlen, chairman and Mrs. E. E. Kirkwood, co-chairman. Guest speaker was Dr. Merrill D. Evans, whose topic was "Geriatrics." Mrs. W. O. Mermis, president, and Mrs. C. A. Gustafson, past-president, presided at the tea table.

The Study Group met on Feb. 6 at the home of Mrs. Herman Ipp.

MONTGOMERY

Mrs. W. L. Slagle was hostess to members of the Montgomery County Auxiliary at a tea on Dec. 9. The Miami Valley Nightingale Choir sang Christmas music and a reading was given by Gwennie Mumma.

Mrs. Louis Loeber was chairman of the Jan. 13 luncheon meeting held at the Dayton Art Institute. A special tour of the Institute followed the business meeting.

OTTAWA

A Christmas party with a gift exchange and social hour followed the Dec. 11 meeting of the Ottawa County Auxiliary held at the home of Mrs. James Rhiel. Mrs. A. D. Miessner provided Christmas tray favors for the hospital. Mrs. W. P. Shortridge recently assisted the County Tuberculosis Society. Mrs. William Duffendock is active in the newly formed council for underprivileged children in the Genoa area, and has discussed the question of socialized medicine before two groups.

Mrs. A. A. Brindley, Toledo, was a guest at the Jan. 15 meeting of the Ottawa County Auxiliary held at the home of Mrs. A. D. Miessner. Plans were made to provide an ice cream

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and cake treat for the residents of the County Home during the month of February.

RICHLAND

Mrs. Harold Andrews reviewed Nina Brown Baker's "The Cyclone in Calico" at the Jan. 12 luncheon meeting of the Richland County Auxiliary held at the Mansfield-Leland Hotel.

During the business session, the group voted to contribute $100.00 to the American Medical Education Foundation. This money was raised at a booth where baked goods, home made gifts, *Today's Health* subscriptions and miscellaneous items were sold at Richland County's first Health Council bazaar held in the Elks Home in Mansfield in December.

Mrs. Donald Dewald spoke on "Geriatrics" at the Feb. 2 meeting held at the Women's Club. At the business meeting conducted by the vice-president, Mrs. Robert Wolford, it was voted to contribute $25.00 to the Friendly House Golden Age club. A committee was appointed to study additional needs of this organization.

ROSS

The January dinner meeting of Ross County Auxiliary was held at Allyn's dining room. A committee to formulate plans for nurse recruitment this spring was appointed. Mrs. L. T. Franklin was named chairman of a bake sale to be held in February. Mrs. R. P. Giesler conducted the hospital guild meeting that followed.

STARK

Mrs. Paul Hofman, violinist; Mrs. Joseph J. Leven, pianist; and Mrs. George Wilcoxon, vocalist; presented the program for the Christmas tea of Stark County Auxiliary held at the Canton Woman's Club on Dec. 9. Seventy Christmas gifts were contributed for distribution to needy children, through the Visiting Nurse Society.

A number of members assisted the Stark County Tuberculosis and Health Association on Dec. 11 and 12. Mrs. F. F. Van Dyke was chairman of a committee which prepared refreshments and holiday decorations for the Dec. 17 meeting of the Live Long and Like It Club.

The Woman's Auxiliary to the Stark County Medical Society met on Jan. 12 at the Y. W. C. A. Dr. L. W. Leavenworth presented a travelog on Holland, France and Spain. Mrs. Homer I. Keck, who presided at the business session, announced that proceeds from sales tax stamps would be used to purchase photographic equipment for the Stark County Board of Health. Refreshments were served by a committee headed by Mrs. K. E. Greenwalt, chairman, and Mrs. Emerson Gillespie, co-chairman.

TRUMBULL

Members of the Trumbull County Auxiliary were guests of the Medical Society at a dinner-dance in December.

A luncheon meeting was held at the Trumbull

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Country Club on January 16. The motion picture film, "Guard Your Heart," was shown by the Youngstown Area Heart Association. Dr. David L. Beers of Warren gave a brief discussion of the subject and conducted a question and answer period. Mrs. E. L. Weden of Youngstown gave an interesting talk on the history of the Heart Association and explained the constructive work accomplished by the organization.

During the business meeting, plans for the Gardenia Ball were discussed.

Two Conferences for Reserve Officers To Be Held in Ohio

Two Second Army Medical Orientation Conferences will bring interesting and educational programs to Ohio medical reserve officers. One of these conferences will be held in Cleveland on March 14 and another in Cincinnati on March 15.

The Cleveland conference will be in the Hollenden Hotel and the Cincinnati conference in the Netherland Plaza Hotel. Registration in both instances will be from 10:00 a. m. until 1:30 p. m., when the first program event begins. Social hour and dinner will be 5:00 to 7:00 p. m., with the program ending at 9:00 p. m.

Following are samples of what reservists will receive:

Colonel George E. Leone, Second Army Surgeon, will tell how his command is cutting costs of hospital operation while increasing patient care.

Colonel James B. Mason, special assistant to the Surgeon General in Washington, will discuss the new laws governing the reserve status of medical personnel.

Dr. Paul M. Linebarger, intelligence section representative of the Second Army, and professor of Asiatic Politics at Johns Hopkins University, will give a "Field Report on the Communist Challenge." He will speak from first hand experiences in the Far East and particularly Korea.

Recent advances in the field of Army medical research and development will be given by Colonel G. J. Collins, Army's Medical and Research Development Board.

Special notice of these meetings have not been sent to all medical reservists because many medical reserve officers are listed only in the general reserve officers' files.

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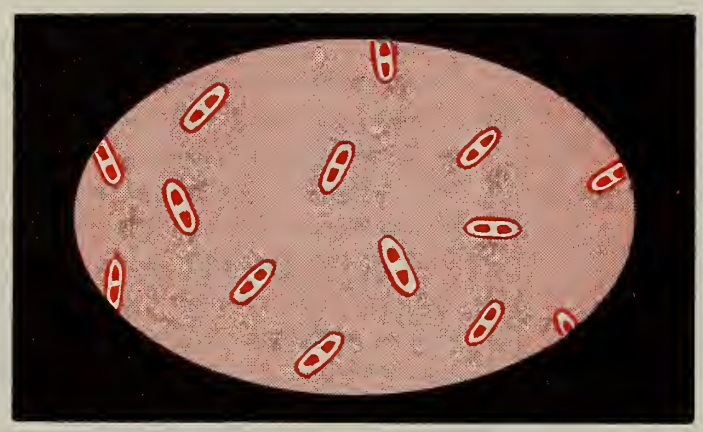
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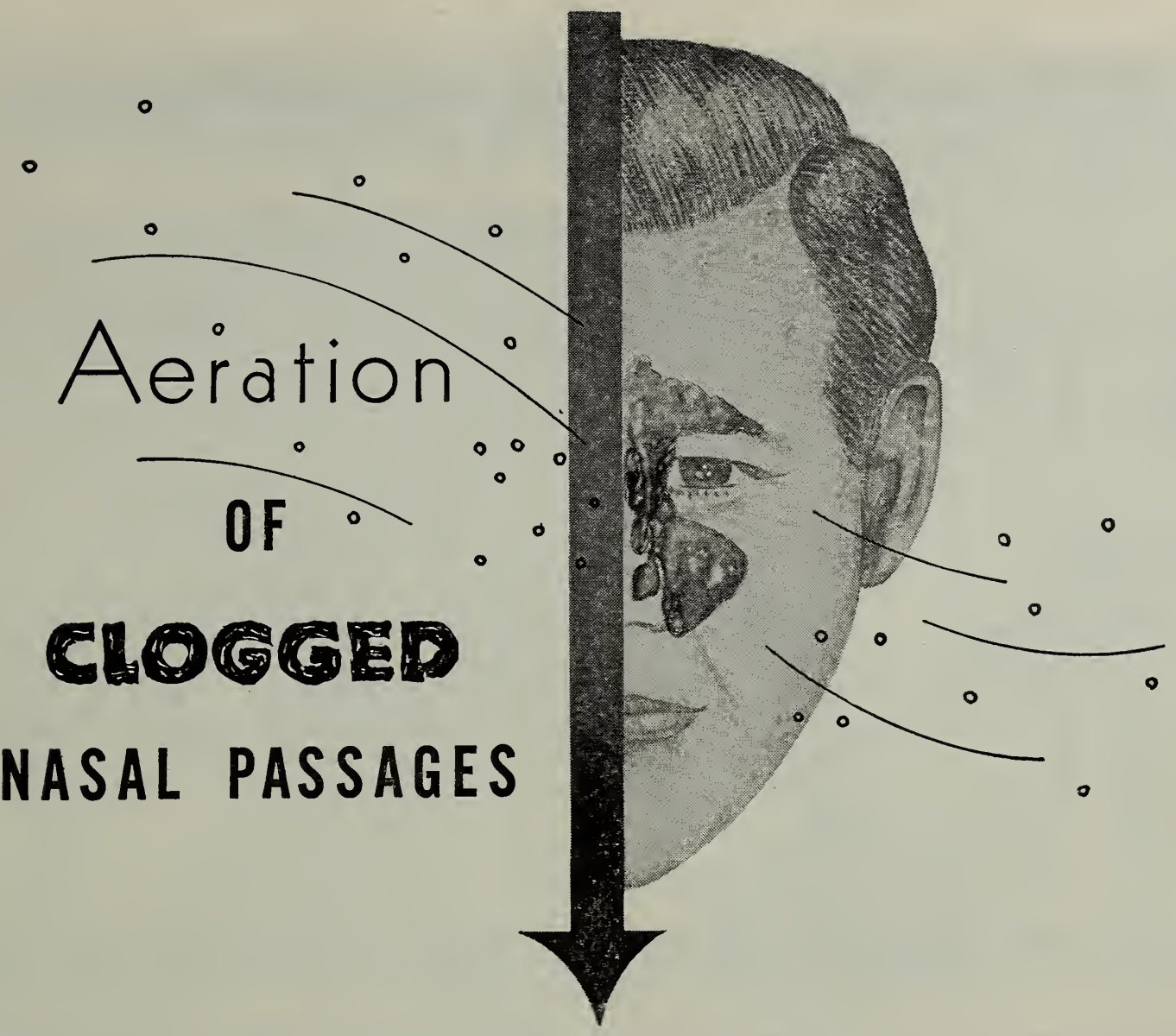
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1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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lotte Ames, Secretary. Xenia. 2nd Thursday, monthly.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

1951: Year Book of Dermatology and Syphilology, edited by Marion B. Sulzeberger, M. D., and Rudolf Baer, M. D., ($5.50. *Year Book Publishers, Chicago, Ill.)*. To most physicians the field of skin diseases remains something for which one or two ointments either cure or do not, something that may not get well but at any rate the patient will not die. The high light of the year book has been the introductory chapter on treatment in each year for several years. This year is no exception. The essay on "Some common errors in the management of skin diseases" is another helpful 30 pages. In all a handy volume especially valuable to everyone seeing patients.

Cowdry's Problems of Ageing, edited by Albert I. Lansing, Ph. D., ($15.00. Third Edition. *Williams & Wilkins, Baltimore, Md.)*, covers the biological and medical aspects of the subject and brings together recent accounts of the problem integrated with a number of contributions from sociological and economic lines of inquiry. Only a small part of what is known is used by our people to live healthier, more useful and longer lives. This book should help our leaders motivate the rest of us to make use of the information which is clearly presented in this book. It represents a real contribution to Gerontology.

1952 Year Book of Medicine, edited by Paul B. Beeson et al., ($6.00. *The Year Book Publishers, Chicago, Ill.)*, maintains the high standards of editorial abstracting that we have come to expect of this group of editors. Scores of significant advances in medicine are detailed and commented upon by an expert staff. A few evenings spent with this book will amply repay any physician who wishes to keep abreast of the times.

Culdoscopy, by Albert Decker, M. D., ($3.50. *W. B. Saunders Co., Philadelphia, Pa.)*, presents a new technique in gynecologic and obstetric diagnosis and is the first attempt to describe it in a comprehensive manner.

Synopsis of Genitourinary Diseases, by Austin I. Dobson, M. D., and Donald L. Gilbert, M. D., ($4.00. Fifth Edition. *C. V. Mosby Co., St. Louis 3, Mo.)*. The demand for another edition speaks for itself. The principal changes have to do with antibiotics and chemotherapy. Many new and better illustrations have been added.

New and Nonofficial Remedies—1952, issued by The Council on Pharmacy and Chemistry of the American Medical Association, ($3.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)*, contains descriptions of the articles which stand accepted by The Council as of January 1st, 1952. The book and its usefulness in previous years is too well known to require further description.

The Old Farmer's Almanac—1953, by Robert B. Thomas (No. CLXI. 25¢. *Yankee, Inc., Dublin, New Hampshire)*. Those of us who were raised in the country enjoy the annual appearance of this almanac which meant so much to our Yankee grandmothers. So we commend to you the 161st edition of this dependable book.

Food Science—A Symposium on Quality and Preservation of Foods, edited by E. C. Bate-Smith and Thomas Norman Morris, ($8.00. *Cambridge University Press, New York 22, N. Y.)*, deals with the rapidly growing science of storing, preserving and transporting foods between production and consumption. Some 26 British authorities have contributed to this symposium. It will serve industry well. It also contains a wealth of information that we physicians should know. Finally, food concerns us all and so there is much here for everyone.

The Narcotics Menace, by Alwyn J. St. Charles ($3.00. *Borden Publishing Co., 3077 Wabash, Los Angeles 33, Calif.)*, is a complete story of the business of dope peddling and addiction, told by a law enforcement officer of long experience.

Forensic Medicine, by Keith Simpson, M. D., ($4.50. Second Edition. *Edward Arnold & Co., London, Eng.;* distributed by *Williams & Wilkins Co., Baltimore 2, Md.)*, is a book for physicians interested in crime detection and the broader field where medical matters come into relation with the laws of Britain.

Scientific Autosuggestion For Personality Adjustment and Development, by Alfred E. Johns, Ph. D. ($2.95. *Associated Booksellers, P. O Box 108, Murray Hill Station, New York 16, N. Y.)*, describes Couéism as it has been perfected by the author.

New Teeth for Old, by Victor H. Sears, D. D. S., ($3.00. Second Edition. *C. V. Mosby Co., St. Louis 3, Mo.)*, is an attempt to allay the fears of the person about to lose his teeth by a former professor of Prosthetic Dentistry, New York University. He reassures the patient that his looks will not be changed and that he can eat as well or even better than before.

Congenital Anomalies of the Heart and Great Vessels, by Maurice A. Schnitker, M. D., ($8.00. *Oxford University Press, 114 Fifth Ave., New York City)*, gives concise descriptions of these interesting and increasingly important developmental defects, done in a simple, clear style with

the practitioner in mind by one of their own members from Toledo.

Operating Room Technic, by St. Mary's Hospital, Rochester, Minn., ($6.50. Fourth Edition. *W. B. Saunders Co., Philadelphia, Pa.).* Since 1924, the instructions for nurses and assistants at the Mayo Operating Room have appeared in this manual. It comes now brought up to date for the first time in 15 years.

Electrotherapy and Actinotherapy, by E. B. Clayton, M. B., B. Ch., ($4.00. Second Edition. *Baillière, Tindall & Cox, London:* Distributor, *Williams & Wilkins Co., Baltimore 2, Md.).* A revision of a standard text of interest to all students and practitioners of physical therapy.

Cornell Conferences on Therapy, Volume V, edited by Harry Gold, M. D., ($4.00. *Macmillan Co., New York, N. Y.),* presents completely modern thought applicable to today's medical problems by exploring some aspect of special interest, by analyzing the evidence on the controversial points of opinion and practice, and elaborating the physiologic, pharmacologic, and chemical bases of treatment.

Experimental Hypnosis, edited by Leslie M. LeCron, ($6.00. *Macmillan Co.. New York 11, N. Y.).* A clinical psychologist and authority on hypnosis has brought together and edited some 20 papers by outstanding psychiatrists in the field. Result: a wealth of information on experiments in hypnosis which professional persons and laymen alike can read with understanding.

Emergency Surgery, by Hamilton Bailey, F. R. C. S. (Eng.), ($5.00. Sixth Edition. *Williams & Wilkins Co., Baltimore 2, Md.)*—issued in five parts, of which this is Part IV. It deals with the lungs, the heart, the spine, the head, the face, the neck, and extremities.

Be Happier, Be Healthier, by Gayelord Hauser, ($3.00. *Farrar, Straus & Young, 101 Fifth Ave., New York 3, N. Y.).* The popular author of **Look Younger, Live Longer** (sold 750,000 copies) comes back now to add to his dietary advice new matters pertaining to the personal and social adjustment necessary for health and happiness.

Gas and Air Analgesia in Midwifery, by G. H. T. Stovin, ($2.25. Second Edition. *Staples Press, London and New York),* is designed for midwives, nurses and students. There is a new chapter on the care of the unconscious patient.

Practical Blood Grouping Methods, by Robert L. Wall, M. D., ($5.00. *C. C. Thomas, Springfield, Ill.),* presents all the latest information on all aspects of immunohematology from the Department of Research Medicine of the Ohio State University.

1952 Year Book of Pediatrics, by Sidney Gellis, M. D., ($5.50. *Year Book Publishers, Inc., 200 E. Illinois St., Chicago 11, Ill.),* is up to the high standard established by the previous editors, both as to the selection and the abstract work itself.

Marriage, by Herman J. Peters, ($1.50. *Pacific Books, P. O. Box 558, Palo Alto, Calif.),* is a topical outline with self-evaluation instruments for a course in marriage and family relations.

Sex After Forty, by Samuel A. Lewin, M. D., and John Gilmore, Ph. D., ($3.50. *Medical Research Press;* Distributed by *Grosset & Dunlap, Inc., New York 10, N. Y.),* carries the subject of sex forward in the stormy forties and then into the later years of life. The book does much to clear away the clouds of mystery, anxiety, and dread that so often darken the years that should be rich and most worth while.

Diabetic Glomerulosclerosis—The Specific Renal Disease of Diabetes Mellitus, by Harold Rifkin, M. D., Louise Leiter, M. D., Ph. D., and James Berkman, M. D., ($3.50. *C. C. Thomas, Springfield, Ill.).* This condition has taken first place as the cause of death in diabetic children after 20 years of their metabolic disease. In addition to focusing our attention on this complication as a distinct entity, the problems pressing for investigation are adequately presented.

Acute Peripheral Arterial Occlusion, by William D. Holden, M. D., ($2.35. *C. C. Thomas, Springfield, Ill.).* Four lectures summarizing the subject by the professor of surgery at Western Reserve University.

Relax, Here's Your Baby, by Margaret Gamper, R. N., ($3.50. *Campus Service, Chicago.* Distributed by *Chicago Medical Book Co., Jackson & Honore Sts., Chicago 12, Ill.),* promotes "babies by relaxation" following the idea of Dr. Grantly Dick Read. The author's experiences qualify her to take this stand. Certainly any effort to reestablish childbirth and do away with "deliveries" is to be commended.

Careers for Nurses, by Dorothy Deming, R. N., ($4.50. *A McGraw-Hill Book, New York 18, N. Y.),* presents a systematic investigation of the job opportunities for nurses. It contains much material designed to help a nurse select a specialty best suited to her interests. Fifty specialties in all.

The Special Diet Cook Book, by Marvin Small, ($2.95. *Greystone Press, 100 Sixth Ave., New York 13, N. Y.),* contains over 1200 recipes and 50 pages of illustrated charts. Low Calorie, Low Sodium, Diabetic Diet, High Residue, Bland, Low-Fat and Low Cholesterol, and High Calorie Diets are given, with an introductory blessing by James R. Wilson, M. D., Secretary, Council on Foods and Nutrition for the A. M. A.



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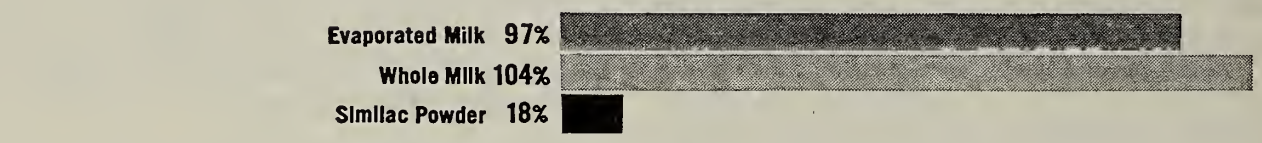
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JONATHAN FORMAN, M. D., *Editor*

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The Indications for and the Results of Surgery In Congenital Cardiovascular Diseases*

SAMUEL KAPLAN, M.D., and JAMES A. HELMSWORTH, M.D.

SURGICAL treatment of certain types of congenital heart disease has progressed rapidly since the report of the first successful ligation of a patent ductus arteriosus by Gross and Hubbard. Since that time surgical therapy has been introduced successfully in the management of specific kinds of cyanotic heart disease, such as tetralogy of Fallot. Other congenital cardiovascular diseases amenable to surgery include coarctation of the aorta and lesions of the pulmonary outflow tract.

This communication reports the experience gained in the surgical management of 100 patients with congenital cardiovascular diseases who have been treated at the Cincinnati Children's and General Hospitals since January, 1949.

PATENT DUCTUS ARTERIOSUS

Indications for Surgery: Irrespective of the age group, patients with symptoms attributable to patency of the ductus arteriosus will derive great benefit from surgical closure of the abnormal shunt. These symptoms include incipient or frank congestive heart failure and physical retardation of growth in children. All patients with subacute bacterial endarteritis should be treated with antibiotics and surgery, the latter being performed early or delayed, depending upon the efficacy of the drug therapy.[1]

The indications for surgery in the asymptomatic patient must be considered in the light of the natural course and prognosis of the disease and the surgical mortality rate. Keys and Shapiro,[2] who studied the autopsy evidence obtained from 60 adult cases, concluded that the presence of a patent ductus arteriosus coincided with an average reduction in life expectancy of about 23 years in men and 28 years in women. Expressed in another way, those who were alive at the age of 17 years had a life expectancy which averaged about one-half of that of the population as a whole. Similar experiences have been reported by Bullock et al., and clinical impressions corroborate the foregoing pathological data.

Gilchrist, Campbell, Sellors, and Gross maintain that it is unusual to see a patient with a patent ductus arteriosus after the age of 40 years, but there are occasional case reports of patients living a normal span of life with perhaps little or no cardiac embarrassment. Such a benign outcome is by no means the rule, and it is evident that many children or young adults who have this anomaly will have their lives jeopardized by one of the several complications, the frequency of which is large enough to make it clear that

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patent ductus arteriosus is not an innocuous lesion.

Because the mortality rate from surgical treatment of this lesion is low, we believe that ligation or division of the ductus is indicated in the asymptomatic patients between the ages of three to 35 years. Surgical therapy in the younger age groups can be performed with relative facility, whereas in older individuals the regional vessels are more rigid and the cardiac reserve is reduced. For these reasons it is probably wise to advise against the use of surgery in the asymptomatic patients over the age of 35 years. However, if important symptoms develop in this age group, there should be no hesitation to proceed with surgery.[1]

Results of Surgery: Forty-two patients between the ages of nine months and 34 years with isolated patent ductus arteriosus have been subjected to surgery since January, 1949. In 40 instances the ductus was ligated and in two, division and suture of the ductus were performed. There were neither deaths nor postoperative complications and the average duration of hospital stay after surgery was 12 days. All these patients are doing well at the time of writing and none shows evidence of any cardiovascular defect.

In 14 of these patients the major presenting symptom was excessive exertional dyspnea. In all these there was evidence of cardiac enlargement and, according to roentgenographic and electrocardiographic evidence, the chamber mainly involved was the left ventricle. In these patients the diameter of the ductus, measured at operation, was one centimeter or more, indicating the presence of a large shunt. In all instances the exercise tolerance has returned to normal since surgery and the heart size has decreased to within normal limits.

Stunted physical development was the major symptom in seven other patients. Since surgery these patients have improved remarkably and within one year have gained up to 11 pounds in weight and grown up to three inches in height. Nineteen patients were asymptomatic before surgery and continue to remain perfectly well postoperatively. Two cases of subacute bacterial endarteritis responded to antibiotic therapy prior to ligation. Since surgical treatment there have been no cases of infection of the ductus and no instances of recanalization.

The "machinery" murmur typcial of this defect was present in thirty-six cases. The murmur disappeared in all instances and was replaced by two normal heart sounds. However, in six patients a harsh systolic murmur only was audible and its presence was recorded phonocardiographically before operation. The diagnosis was confirmed by cardiac catheterization in these cases and a large ductus was found at thoracotomy. In two cases a Grade I systolic murmur remains after surgical ligation. We believe that these murmurs are related to turbulence of blood in a dilated pulmonary artery and not to recanalization of the ductus. Both these patients underwent cardiac catheterization before operation and the presence of an associated auricular or ventricular septal defect could not be demonstrated.

TETRALOGY OF FALLOT

Indications for Surgery: The majority of patients with tetralogy of Fallot are sufficiently incapacitated to justify some form of therapy which will increase the degree of pulmonary circulation. For surgery to be successful an accurate diagnosis is necessary. The diagnosis can usually be made after a careful history and physical examination and roentgenographic and electrocardiographic studies.

The operative risk varies with the age of the patient,[3] the mortality rate being higher in infants and adults. It appears that the best results are obtained in children between the age of two years and puberty. However, if incapacitating symptoms occur before the age of two years, surgery is urgently indicated. Taussig has pointed out that "It is not justifiable to let a baby die of anoxemia while waiting for him to reach a more favorable age."

The surgical procedure performed in our patients was either a subclavian-pulmonary artery or an aortic-pulmonary artery anastomosis. When these procedures are to be performed it is desirable to know the size, structure and position of the pulmonary and subclavian arteries, as well as that of the aorta. The latter structure arches to the right in 20 per cent of patients and may be identified on posteroanterior films of the chest and by barium esophogram. The size and position of the pulmonary and subclavian arteries can be assessed from angiocardiographic studies.

We have carried out more than fifty such studies in cases of suspected tetralogy of Fallot and have concluded that if the clinical, roentgenographic and electrocardiographic pictures are typical these investigations will confirm the diagnosis, but will not provide additional information. In patients with typical clinical findings it is nearly always found that the size and position of the systemic vessel and the pulmonary arteries are favorable for surgical anastomosis. In the atypical cases which comprise 20 per cent of the group, angiocardiography and/or cardiac catheterization may be necessary to confirm the diagnosis and to determine the positions and sizes of the great vessels.

In a small minority of cases of tetralogy of Fallot there is little disability from the lesion. In many of these instances there is a collateral bronchial circulation to the lungs which permits adequate pulmonary blood flow. Rarely the ductus remains patent; when it does it produces the same physiologic result. These patients suffer little incapacity and aside from some mild exertional

dyspnea and cyanosis they lead normal lives. Their resting arterial oxygen saturation is usually above 80 per cent and they do not require surgical therapy.

Results of Surgery: Thirty-five patients with tetralogy of Fallot have undergone surgery since January, 1949, at these hospitals. The age at time of surgery was between six months and 15 years. A Blalock-Taussig anastomosis was performed in 16 patients, a Pott's anastomosis in 18 and a Barrett procedure[4] in one. In all instances the approach was through a left posterolateral thoracotomy.

There have been no rigid criteria for choosing between a Blalock-Taussig or a Pott's procedure. In the former operation the inner opening of the anastomosis depends on the inner diameter of the subclavian artery, whereas in the Pott's procedure, the size of the side to side anastomosis does not depend on the caliber of the vessels. We have adopted a working rule that the Pott's procedure is performed in patients under the age of three years, whereas the Blalock-Taussig procedure is performed in older patients. If the aorta arches to the right we feel that the procedure of choice is a Blalock-Taussig operation through a left thoracotomy, irrespective of the age of the patient. If tetralogy of Fallot is complicated by dextrocardia and situs inversus, a Blalock-Taussig anastomosis is performed through a right thoracotomy.

In this group of 35 patients there were three deaths with an overall mortality of about 8.5 per cent. Details of the patients that succumbed are as follows:

CASE REPORTS

(1) The patient was a six month old white boy who had suffered from recurrent severe hypercyanotic attacks. After a Pott's anastomosis was performed the attacks ceased and he did well for a period of five months. Then cyanosis recurred and he was re-admitted in a comatose state. A right hemiplegia was noted and the "machinery" murmur, which had been clearly audible after the operation, had disappeared. He died without regaining consciousness. At autopsy the site of anastomosis was found to be occluded by an endotheliazed membrane which had grown from the walls of the aorta and pulmonary artery. The immediate cause of death was cerebral thrombosis.

(2) The patient was a 20 month old white boy who had experienced marked reduction of exercise tolerance and intense cyanosis. At the time of operation it was noted that a large bronchial artery supplied the right lung and that occlusion of this vessel produced a marked fall in blood pressure and tachycardia. It was technically impossible to apply Pott's clamps without occluding this vessel and the operation had to be terminated without the production of an anastomosis. The patient died one hour after operation.

(3) The patient was a 12 month old white baby girl who had suffered from recurrent hypercyanotic attacks. Cardiac catheterization and angiocardiography confirmed the suspected diagnosis of tetralogy of Fallot, and the latter study demonstrated pulmonary arteries which were thought to be sufficiently large for an anastomotic procedure. At operation the left pulmonary artery was found to be embedded in dense fibrous tissue and measured three millimeters in diameter. It was felt that this structure was inadequate for anastomosis and the procedure was terminated. The patient died twenty-four hours after surgery.

As pointed out previously, the mortality rate from Blalock-Taussig or Pott's anastomosis is closely related to the age of the patient, the rate being higher in infants and adults. It will be noted that the three patients who died after surgery were under the age of two years. There were no deaths in the twenty-six patients who were over the age of two years at the time of surgery.

There were three instances of postoperative chylothorax in which repeated thoracentesis were necessary for about 50 days after the surgical procedure. These patients have improved remarkably and there has been no necessity for further thoracentesis. In three patients a temporary Horner's syndrome was present postoperatively. In one instance postoperative congestive cardiac failure occurred, probably as a result of the large size of the Pott's anastomosis which, at the time of surgery, measured seven millimeters in diameter. This patient responded to digitalization and has continued to improve during the 18 month postoperative period. His exercise tolerance is now almost normal and cyanosis has disappeared.

The operation has greatly benefited more than 90 per cent of patients in this series. The average duration of hospital stay after surgery has been 12 days. In infants who suffered from hypercyanotic attacks before surgical intervention there has been no recurrence of these attacks. There has been a striking improvement in babies in whom there was a retardation of physical activity because of dyspnea. We have observed instances where before operation children between the ages of nine and 18 months could crawl only a few yards. Within three weeks after surgery these patients have crawled without difficulty and within a few months have walked without incapacity.

Exercise tolerance was also markedly increased in patients who were old enough to be ambulatory prior to surgery. Before operation these patients were able to walk only a distance of 5 to 200 yards. After operation, in nearly all of the patients, exercise tolerance was normal and in all instances the habit of squatting was lost. The degree of cyanosis was also markedly diminished after surgery and in many cases it disappeared. Similarly, the degree of clubbing of the fingers and toe nails was diminished and in some cases disappeared. In all cases a "machinery" murmur, sometimes accompanied by a coarse thrill, was detected after operation. This murmur is indicative of a functioning anastomosis and is permanent.

The heart size, which is typically normal in

tetralogy of Fallot, remained normal on clinical examination after surgery, but there were some instances where the heart size was thought to be somewhat larger on roentgenographic studies after operation. Similar experiences have been reported by Leininger et al.[5] In all cases there was improvement in the degree of pulmonary vascularity after operation, as determined by radiography. There was no change in the electrocardiogram and evidence of right ventricular hypertrophy remained after surgery. If the red cell count and hemoglobin were elevated, they usually returned to normal after the anastomosis had been performed. The average hemoglobin before operation in this series was 17.3 Gm. per cent. After surgery this figure was reduced to an average of 13.8 Gm. per cent.

COARCTATION OF THE AORTA

Although many patients with coarctation of the aorta live well into middle life without serious handicap, the majority succumb before this period. Abbott found that the majority died between the ages of 20 and 40 years. Reifenstein, Levine and Gross[6] reviewed 104 autopsied cases of coarctation of the aorta and found that the average age of death was 35 years. In Crafoord's experience, 90 per cent of patients died before the age of 50 years. Gross stresses the fact that many patients live to an old age, but that this is not the usual course of events. He found that only 26 per cent were not handicapped by their lesion. Twenty-two per cent died, usually in the third decade, of subacute bacterial endocarditis or endarteritis. Twenty-three per cent died, usually in the second or third decade, from rupture of the aorta. In 29 per cent death was attributable to congestive heart failure or cerebral hemorrhage, both of which resulted from the hypertensive state.

The natural course in individual cases is unpredictable. Crafoord found that symptoms may start as early as the age of five years and are nearly always present at the age of twenty-five. We have observed and successfully treated coarctation of the aorta in an infant aged four months who had been in congestive heart failure. Sudden death may occur at any time from acute heart failure, rupture of the aorta or one of its branches, or cerebral hemorrhage.

Before surgical therapy is advised individual cases should be assessed in the light of the previously mentioned statements. In our experience the optimum age for surgery is between six and 15 years. Resection and anastomosis of the area of coarctation is performed with relative facility before the age of 15 years, because in the majority of cases the degree of degenerative change around the coarctation is usually limited. However, surgery is indicated in patients under the age of six years if incapacitating symptoms are present. The factor determining the upper age limit for successful surgical repair is the degree of arteriosclerosis around the coarcted segment. Most authors believe that the upper age limit for surgery is about 30 years. If the diagnosis is first established after this age, surgical therapy should be advised only if symptoms are present. Blalock has successfully treated patients up to the age of 40 years.

Results of Surgery: Nine patients with coarctation of the aorta have been treated by resection of the stenotic segment and end to end anastomosis of the aorta. The ages at the time of operation were between four months and 21 years. The postoperative courses were uneventful and all patients are alive and well. Prior to operation one or more of the classical symptoms associated with this lesion were present and the average blood pressure was 160/110 millimeters of mercury.

After the anastomosis was completed a striking improvement in the degree of femoral artery pulsations was noted. Patients often volunteered that there was a definite increase in the temperature of their lower extremities. Improvement or disappearance of headaches and/or epistaxes was noted in the postoperative and follow-up periods. The relief of hypertension was not instantaneous. As has been observed by others there was a delay of three to four weeks before normotensive levels were reached. The reason for this delay is not clear. However, the recorded blood pressure in the lower extremities increased in the postoperative period and within three to four weeks after surgery exceeded that in the upper extremities.

In one patient, aged four months, resection of the coarctation was undertaken because of recurrent episodes of congestive heart failure. There have been no episodes of cardiac failure since surgery and the child continues to do well. In all patients there was a reduction in intensity of the systolic murmur after operation, but a Grade I to II systolic murmur is still audible in all. It may be related to persistent enlargement of the collateral vessels or perhaps be produced by aortic valve deformities which may complicate coarctation of the aorta.[6]

OTHER CONDITIONS AMENABLE TO SURGICAL THERAPY

Three patients with aortic arch abnormalities underwent surgical therapy because of recurrent severe pneumonitis. In two instances the underlying lesion was a double aortic arch and in the other the abnormality was an aberrant right subclavian artery. These patients remain asymptomatic since treatment and have not had any recurrence of respiratory infections and are growing and developing normally. The ages at the time of surgery were two, nine and 17 months.

Pulmonary valvulotomy has been performed on three patients with isolated valvular pulmonic

stenosis and in two patients with tetralogy of Fallot. The recovery from surgery was uneventful, but the follow-up period has been too short to permit an adequate assessment of the efficacy of this treatment. However, a definite improvement in exercise tolerance is already present.

Lobectomy has been performed on two patients with localized pulmonary arteriovenous fistulae. They made uneventful recoveries and showed an impressive disappearance of cyanosis which had been intense prior to surgery.

Tricuspid atresia with under-developed right ventricle presents a clinical picture somewhat reminiscent of tetralogy of Fallot. However, symptoms commonly appear at an earlier age and death is not unusual in the first six months of life. Although the diagnosis was made in nine patients, five were so ill from heart failure and intercurrent infection that surgical therapy could not be instituted. Pott's procedure was carried out in the remaining four patients. Two died within one week of surgery. The other two patients have been followed for a period of about 18 months and continue to do well with a near normal exercise tolerance and improvement of cyanosis. It is of interest to note that the two surviving patients were over the age of two years at the time of operation.

SUMMARY

1. Surgical management of one hundred patients with congenital cardiovascular disease is described.

2. Indications for surgery in cases of patent ductus arteriosus are discussed and the results of treatment in 42 patients are described.

3. The results of surgical treatment of 35 patients with tetralogy of Fallot are discussed.

4. The natural course of cases of coarctation of the aorta is described and the results of the surgical management of nine cases are discussed.

5. The surgical treatment of aortic arch anomalies, valvular pulmonic stenosis, pulmonary arteriovenous fistulae and tricuspid atresia with under-developed right ventricle is briefly described.

Addendum—Since this paper was prepared, the 34 year old patient with patent ductus arteriosus has shown evidence of recanalization of the ductus.

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A Case of Homologous Serum Jaundice After Transfusion of Stored Whole Blood

Admitted to St. Thomas Hospital, Akron, Ohio, on May 7, 1952, for hysterectomy was a 37 year old white female. Following the operation she received one unit of whole blood obtained from the Red Cross Regional Blood Center. The patient made an uneventful recovery and was discharged on the 9th postoperative day.

Eighty days after the blood transfusion the patient was readmitted to this hospital. She complained of nausea, vomiting, and loss of appetite. She noticed that her stools had become "light" and her urine "very dark." The only significant physical finding was a generalized jaundice, grade II. **Laboratory findings:** Icterus index 91, thymol turbidity 5 Maclagan units, cephalin flocculation 4 plus, coagulation time 3 minutes, and bleeding time 40 seconds. Blood count and urine analysis were within normal limits. A **diagnosis** of homologous serum jaundice was made. After 18 days of hospitalization she was discharged as improved.

On July 19, 1952, the hospital blood bank was informed by the Regional Blood Center that the donor of the blood used for this patient had been admitted to a neighboring City Hospital suffering from homologous serum jaundice.

The donor, a 21 year old male, presented himself to the Regional Blood Center on April 17, 1952. He gave no history of malaria, tuberculosis, diabetes, undulant fever, jaundice, heart or renal disease, and denied hypodermic injections as well as recent surgical operations.

Five weeks before his admission he noted nausea, and nine days afterwards he developed jaundice. The hospital course and his recovery were uneventful.

This donor had made his first donation 5 months previously. His blood was then used for a plasma pool. His last and final donation was not used because the blood had become outdated.

DISCUSSION

This case is reported to call attention to the danger of transmission of homologous serum jaundice by transfusion of whole blood. We might think that an incident like this should be the exception. However, D. R. Fitch and others[1] have recently reported on the incidence of carriers of the hepatitis virus in 3965 donors. Employing a battery of liver function tests they found 436 of them to be proven carriers of the virus, and 55 per cent of the total to be equivocal ones. This is indeed a surprisingly high percentage of potential sources of infection.

It seems that at the present the performance of liver function tests on all blood donors may be the only means to prevent transmission of homologous serum jaundice by transfusion.—From the Blood Bank of St. Thomas Hospital, Akron, Ohio. By L. B. Mehl, M. D., resident in gynecology and obstetrics, St. Thomas Hospital.

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Lesions Producing Bursitis-Like Symptoms

Importance of Radiographic Study Before Treatment of Bursitis

JOHN D. OSMOND, JR., M. D.

THERE are many who still believe that the diagnosis of bursitis or peritendinitis of the shoulder, hip or other joint can be made on the basis of history and physical findings alone. It has been our experience that numerous other conditions can produce similar symptoms and that adequate radiographic examination is, therefore, absolutely necessary before surgical, medical, roentgen or physical therapy is administered. The value of roentgen therapy in acute, subacute, and even some chronic cases of peritendinitis (bursitis) of the shoulder, hip, elbow, etc., has been thoroughly established.[3, 6] This information has been so well disseminated that frequently patients are referred directly for roentgen therapy without the diagnosis being confirmed by radiographic examination.

Symptoms of bursitis or peritendinitis include limitation of motion of the involved joint, and pain which may remain localized or be referred distally in the extremity. Pain is often worse at night. The onset of these symptoms may be spontaneous or follow single or repeated episodes of trauma.

PATHOLOGIC CHANGES MAY BE CAUSE

It has been our practice to obtain preliminary x-ray films of the symptomatic joint even though the patient with so-called typical symptoms of bursitis may have been referred specifically for roentgen therapy. In radiographic studies of patients presenting clinical findings of bursitis we have found several cases where such a lesion was not present; instead the symptoms were caused by one of the following:

(a) chip fracture of the greater tuberosity of the humerus;
(b) posterior subacromial dislocation of the head of the humerus;
(c) acute subpectoral abscess;
(d) actinomycosis of the humerus;
(e) tuberculous arthritis of the shoulder;
(f) osteoarthritis (hypertrophic degenerative arthritis) of the cervical spine and/or shoulder joint.
(g) giant cell tumor of the greater trochanter.

Furthermore, bursitis-like symptoms in the shoulder (or hip) can be produced by rupture of the supraspinatus tendon, osteomyelitis, other types of arthritis, sarcoma, or metastasis. Also referred pain from cardiac, cholecystic, or pleural disease may produce similar discomfort in the shoulder.

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RADIOGRAPHIC STUDY

Although fluoroscopic study frequently reveals the presence of a soft tissue calcification, radiography is preferable because faintly calcified soft lesions are easily overlooked by screening alone. It should be added that other abnormalities cannot be excluded as well by fluoroscopy. Moreover, 2.7 per cent of the shoulders of 6,061 normal patients fluoroscoped by Bosworth[1] contained soft tissue calcifications. Therefore, if a calcification is found in a patient suffering with one of the more serious conditions an erroneous diagnosis of peritendinitis might be made.

TECHNIC

The technic of roentgen examination of the shoulder is quite well standardized. The minimum examination consists of two anteroposterior films. One is made with the arm in extreme external rotation and the other in internal rotation. Mid-rotation or vertical studies will demonstrate a small soft tissue calcification on rare occasions. It should be stressed that at least one film must be of adequate size to include the entire shoulder area as well as the shaft of the humerus and the superior portion of that side of the thorax. A 10 by 12 inch film will usually be sufficient for this.

It can be assumed that the clinical diagnosis of peritendinitis has been confirmed when a calcified deposit is demonstrated in the musculotendinous cuff and there is no other pathologic change visualized.

The following brief case histories have been chosen from our files to illustrate the discussion. These cases are rare, inasmuch as we have treated over 1,450 cases diagnosed as bursitis or peritendinitis during the four-year period between 1948 and 1951. It is difficult to explain the fact that the number of treated cases has

From the offices of Drs. Hill, Thomas, Sackett, Schumacher, Osmond, O'Neill, Hannan, and Dundon. Radiographs were presented in an exhibit at the Annual Meeting of the Ohio State Medical Association, Cleveland, May 20-22, 1952.

gradually increased from 149 in 1948 to 552 in 1951.

CASE REPORTS

Case I: The patient, a 37 year old white female was referred for films and therapy of the right shoulder. The history was somewhat vague, but the patient was suffering from moderately severe localized pain in the region of the greater tuberosity of the humerus. There was moderate limitation of abduction and posterior extension. The symptoms were considered quite typical of a subacute bursitis or peritendinitis. Radiographs of the symptomatic shoulder revealed a 1.2 by 0.6 cm. chip avulsion-type fracture arising from the superior margin of the greater tuberosity of the humerus. The patient later recalled that she had suffered a minor injury about two weeks earlier.

Case II: The patient, a 72 year old white male was referred for x-ray therapy of the right shoulder. Severe pain and limitation of motion had been present for two weeks. Radiographs made elsewhere had demonstrated a soft tissue calcification overlying the inferior aspect of the shoulder joint. During additional questioning the patient admitted that he had experienced a convulsive seizure just before the onset of symptoms.

Because of the history of a convulsive-type spasm posterior subacromial dislocation of the head of the humerus was suspected. Additional radiographs proved this lesion to be present. Thomas[7] emphasized that this type of shoulder dislocation is frequently not diagnosed on routine anteroposterior radiographs. In cases with a history of epileptic or other convulsive seizures, posterior dislocation should be suspected and stereoscopic anteroposterior films obtained. If no fracture is associated, a vertical view will absolutely confirm the diagnosis.

Case III: A 62 year old male was referred for radiographic study for suspected bursitis. Pain had been present in the left shoulder for six days. Motion was limited due to the pain. The patient had had dyspnea for the same length of time. Radiographs of the shoulder were negative.

Subsequent physical examination and films of the chest revealed a stony, hard mass in the left supraclavicular region, and a 5 cm. spherical mass in the anterior aspect of the superior portion of the left hemi-thorax. A primary malignant lung tumor with metastases was suspected.

Sixteen days after the onset of symptoms an abscess developed over the anterior aspect of the left shoulder girdle. Following incision and drainage the patient recovered completely and the chest films showed essentially complete clearing. This lesion, known as acute subpectoral abscess, has been discussed by Lawrence and Anglem.[4] They pointed out that disease of the shoulder joint and/or neighboring bursae may be suspected in such cases.

Case IV: A 44 year old male was referred for radiographic examination of the right shoulder for pain of about three months' duration. The pain extended from the shoulder to the elbow and was present almost constantly. Radiographic examination demonstrated an irregular destructive process involving the medullary portion of the humerus. The lesion involved about 12 cm. of the middle third of the shaft. Slight periosteal reaction was present. At operation an inflammatory lesion was found. Culture proved the process to be caused by actinomycosis. Further questioning did not reveal the origin of this disease.

Case V: The patient, a 43 year old male was suspected of having bursitis of the right shoulder and was referred for roentgen therapy. The history was not typical inasmuch as the pain had been present for over ten years. The recurrences were chiefly in the fall and winter. Motion was limited. Radiographic examination of the right shoulder showed marked narrowing of the joint space between the glenoid and the head of the humerus. Areas of absorption were noted along the articular surfaces. Osteoporosis was moderate. The findings were due to tuberculosis.

Case VI: The patient, a 45 year old male was referred with the diagnosis of bursitis. Pain had been severe and constant in the left shoulder for about one month. This was worse at night and pain radiated to the elbow and wrist. Limitation of motion was present. The patient had worn an arm sling for over three weeks. Radiographic study of the shoulder did not demonstrate any pathologic change.

Because of the history of stiffness of the neck for six weeks, radiographs of the cervical spine were made. These demonstrated moderately marked hypertrophic spurring at the margins of the lower cervical vertebral bodies. The shoulder symptoms in this case were due to nerve root pain secondary to the osteoarthritis in the cervical spine.[2] The value of roentgen therapy in this condition has been recently reported by Lundar.[5]

Case VII: A 38 year old male was referred for roentgen therapy to the left hip for peritendinitis. The patient stated that he had had pain and stiffness in the left hip for eight or nine months. This pain radiated down to the knee. Radiographs demonstrated a large osteolytic area in the neck of the left femur extending into the greater trochanter. This was considered to be a benign cystic lesion, most likely a giant cell tumor. Radiographic survey of the skeleton did not show other cystic lesions. A film made elsewhere about two years before did not demonstrate this pathologic change. Operation and microscopic study proved the presence of a benign giant cell tumor.

Case VIII: The patient, a 42 year old male was referred for radiographic examination because of persistent pain in the right shoulder for six months. Peritendinitis had been suspected earlier by another physician, but radiograph made elsewhere at that time did not confirm the diagnosis. Our radiographic study included films of the chest and cervical spine, in addition to the symptomatic shoulder. All but the former were negative.

The film and fluoroscopic study of the chest, however, demonstrated a rounded mass about 5 cm. diameter at the right hilum. Secondarily, there was some elevation and decrease in the excursion of the right side of the diaphragm. Suspected bronchogenic carcinoma was not visualized during bronchoscopy. Subsequently roentgen therapy was administered to the tumor. He died about one year following the onset of pain in the right shoulder.

SUMMARY

Bursitis-like symptoms can be produced by numerous other local as well as distant lesions. In cases suspected of suffering from bursitis or peritendinitis we have found the following path-

ologic changes to be present: chip fracture of the greater tuberosity of the humerus; posterior subacromial dislocation of the head of the humerus; acute subpectoral abscess; actinomycosis of the humerus; tuberculous arthritis of the shoulder; osteoarthritis (hypertrophic degenerative arthritis) of the cervical spine and/or shoulder joint; giant cell tumor of the greater trochanter; and carcinoma of the lung.

In addition, bursitis-like symptoms in the shoulder (or hip) can be produced by rupture of the supraspinatus tendon, osteomyelitis, other types of arthritis, sarcoma, or metastasis. Also referred pain from cardiac, cholecystic, or pleural disease may produce similar discomfort in the shoulder. Therefore, adequate radiographic study is considered necessary to confirm the clinical diagnosis before any form of therapy is administered even in "typical cases of bursitis."

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The Use of Cortisone and ACTH In a Case of Eclampsia

In the event that a person is continuously exposed to stress, as in pregnancy, the resulting general adaptation syndrome of Selye evolves in three distinct stages: (1) the alarm reaction; (2) the stage of resistance; and (3) the stage of exhaustion. We have classified our patient in the third stage at the time cortisone was given. This stage also represents the sum of all nonspecific systemic reactions which had developed as a result of prolonged exposure to stress, to which adaptation for a considerable period of time had developed but could no longer be maintained. It is our belief that cortisone is contraindicated except in the stage of exhaustion.

The clinical and physiologic improvement in our case, following the administration of cortisone to a moribund patient when all previous treatment had failed, indicates in our opinion that this therapy is of merit and in this instance was responsible for the recovery of the patient.—William M. Howdon, M. D., and B. L. Ludwig, M. D., Miami, *J. Florida M. A.*, 39:578, February, 1953.

Increased Incidence and Death Rate In Diphtheria and Pertussis

Diphtheria today shows evidence of increased incidence with a shift to the older age groups on a higher mortality and complication rate. On the other hand, pertussis shows an inclination to increased incidence and severity with a high fatality to the less than 1 year of age group.

It has been more or less the concept that diphtheria is a disease of younger children. However, many cities of the United States where communicable disease records are available show the disease increasing in persons more than 40 years of age and a decline of reported cases in the youngest age group comprising children from birth to 14 years. As early as 1947, it was said that about one half the cases of diphtheria occur in children less than 5 years of age.—Thomas L. Dwyer, M. D., Mexico; *Missouri Medicine*, 50:30, January, 1953.

Trichinosis: A National Problem

Trichinosis is a disease of animals, particularly of swine, which affects man when raw or improperly cooked pork, containing viable trichinae, is eaten. Trichinosis has been shown to have an almost world-wide distribution, exhibiting its greatest endemicity in those countries where pork is often consumed raw, and being lowest in Jewish and Mohammedan areas.

Hall and his associates have published a series of papers concerning examination for trichinae of human diaphragms obtained at autopsy. Of 5,313 diaphragms, 855 showed evidence of trichinae. One person out of six, or about 25,000,000 of those alive today in this country, probably harbor trichinae. To reach this total, there would have to be 350,000 new infections each year. Using a conservative figure of 51 larvae or more per gram as an arbitrary threshold for producing symptoms, 4.5 per cent of all persons infested, or about 16,000, should exhibit clinical symptoms. This estimate far exceeds the annual average of 336 cases (1942, 1951) reported in this country. The difference is due to inadequate reporting, mildness of symptoms, and the difficulties of making a clinical diagnosis.

It is estimated that of the 60,000,000 hogs slaughtered each year, 1.5 per cent or 950,000 are infested with trichinae. While only 40 per cent of the trichinosis in hogs can be blamed on those fed entirely on raw garbage, a majority of the remaining 60 per cent must be due to partial feeding of raw garbage.

Trichinosis is a national problem, not only of public health concern, but of economic importance to producers of pork.—VERNON B. LINK, M. D., medical director, Communicable Disease Center, U. S. Public Health Service, Atlanta, Georgia.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

Anaphylactic Shock Following Administration of Penicillin

IGOR F. NIKISHIN, M. D.

THE known untoward effects of penicillin, are of the type of immunobiologic hypersensitivity, and do not represent a result of direct toxicity of the drug. They mainly consist of urticaria, contact dermatitis, gastrointestinal reactions, arthralgia and drug fever. Each of those signs may occur as the sole manifestation of hypersensitivity, or be a part of a syndrome of the type of serum sickness.

Because of the antigen-antibody mechanism of penicillin reaction, as it has been experimentally demonstrated by positive intradermal reactions,[1] by indirect or passive transfer tests of Prausnitz-Kustner, as well as by precipitin reaction, one has to be aware of possibility of a more serious reaction based on the same mechanism and known as anaphylactic shock. It is beyond the scope of this paper to discuss the similarities and differences between allergy and anaphylaxis as related to manifestations of penicillin sensitivity. Suffice it to say, that anaphylactic shock has been considered to be the most dramatic manifestation of allergy. It is the familiar reaction to the injection of heterologous anti-serum into a sensitive patient which may be produced by the injection of protein containing biologic products, as well as by intravenous injection of certain nonprotein drugs such as arsphenamine, quinine, and thiamine.

This violent reaction is characterized in experimental animal by restlessness, labored respiration, convulsions, and death within a few minutes, and in man by asthma-like condition and failure of the peripheral circulation.[2] The allergic reaction to penicillin occurs in persons with a known sensitivity to that drug, in persons who have never before displayed such sensitivity, and even in persons who had no demonstrable contact with that drug prior to the injection causing the reaction. The sensitivity of persons in the last mentioned group, may be explained by the known possibility of transmission of penicillin from the maternal to the fetal blood circulation through the placenta, and by a sensitivity to molds, which apparently have a common antigenic factor, in addition to the specific antigenic factor.

True anaphylactic reactions to penicillin are rare. We found only five instances reported in the available literature.[3] There are two more cases reported as such, but it seems reasonable to consider one of them, as a delayed allergic reaction, because of the protracted course and formation of rash and fever; and the second, as a severe allergic reaction not accompanied by collapse. The following traits were common to the five cases of true anaphylactic reaction to penicillin:

Submitted November 28, 1952.
Acknowledgment is made to Herbert A. Jones, M. D., Canton, Ohio, for permission to publish this case.

The Author

● Dr. Nikishin, Canton, Ohio, is assistant resident in surgery at Aultman Hospital.

COMMON CHARACTERISTICS

1. All patients with one exemption,[3b] received penicillin at least several weeks prior to the administration which was followed by shock.
2. None of the patients manifested sensitivity to penicillin during previous administrations.
3. Four of the patients received the "exciting doses" intramuscularly, and one reacted to intramaxillar penicillin instillation. The same patient later displayed an anaphylactic reaction following an intramuscular injection.
4. In none of the cases intravenous administration could be proven.
5. The onset of the reaction was described as "almost immediate" or "within 5 seconds," and in no case later than 15 minutes following the injection of penicillin.
6. The reaction was manifested by flushing of the face, choking, wheezing, dyspnea, subjective feeling of tightness in the chest and throat, followed by extreme circulatory depression with a rapid, weak, almost imperceptible pulse, low or unobtainable blood pressure, profuse perspiration, and collapse.
7. Anti-allergic treatment, when administered, was successful. The patients recovered within hours and the attack left no demonstrable sequelae. The history of previous allergies was an inconstant finding, the dose of penicillin had no apparent bearing either on the onset or on the severity of reaction, and neither the sex, race, nor age were of any importance in the occurrence of this syndrome.

TWO REPORTED CASES REVIEWED

Two fatal cases of anaphylactic shock following injection of penicillin were reported. Waldbott[3a] reported the case of a 39 year old woman, in whom the intragluteal administration of 50,000 units penicillin was followed within 5 seconds by flushing of the face, feeling of a strange taste in the mouth and tongue and a feeling of tightness in the throat and nose as well as itching "all over." The face became cyanotic and the patient collapsed over the table, reaching for water. She died immediately. The injection was administered

in the patient's home by her sister, who was an experienced nurse.

As pointed out by Waldbott, the almost immediate onset of the reaction, as well as the complaint of a "strange taste" in the mouth are strongly suggestive of intravenous administration of penicillin, in spite of probably having observed the usual precautions. It is of importance to note, that the fatal injection was performed at the patient's home, apparently under no medical supervision, thus precluding an energetic treatment of this violent reaction.

Higgins and Rothchild[3b] reported the case of a 57 year old male, who developed a cough and a tonic muscle spasm one and one half minutes after an intramuscular injection of 300,000 units of procaine penicillin G. Respirations became gasping, pulse thready, and blood pressure unobtainable. No evidence of obstruction of upper respiratory passages was found on laryngoscopy. Atropine sulfate and aminophyllin were given intravenously, and epinephrine was injected intracardially. In spite of treatment, the patient died ten minutes after the injection of penicillin.

Postmortem examination revealed no gross anatomical abnormalities and no pathologic changes to account for the patient's death. In this case, also, the rapidity of the onset and the severity of the reaction, make it probable, as pointed out by the authors, that in spite of the usual precautions the injection was inadvertently given in the vein.

The small number of reported cases of anaphylactic reaction following injection of penicillin, the severity of that condition, as well as the possibilities of its treatment, are the reasons for presentation of the following case:

CASE REPORT

A 55 year old white female, with no allergic history in the family. In 1919 the patient was subjected to appendectomy with a smooth convalescence; in 1933 she was treated with radium because of a growth on the cervix, after which treatment patient developed an ulcer in the ampulla of the rectum. Since 1950, patient was repeatedly hospitalized for a chronic infection of the upper respiratory passages with fever, chills and hemoptysis of unknown origin. Clinical investigation as well as x-ray studies, including bronchography, failed to reveal the cause of her condition.

Patient was repeatedly treated with various antibiotics to which she reacted by manifestations of sensitivity. Both aureomycin and terramycin administration resulted in a very severe proctitis, and dihydrostreptomycin had to be discontinued because of an intensive itching. Penicillin was the only antibiotic with no untoward effect. Prior to the episode to be described the last injection of penicillin was administered one week before, and was accompanied by no signs of hypersensitivity.

September 25, 1952, patient received an intragluteal injection of 300,000 units of crystalline procaine penicillin G, administered by an experienced and reliable nurse in the office of her family physician. A 22 gauge needle was used. The nurse aspirated the contents of the needle prior to injection of the penicillin and obtained no blood. Two minutes after the injection the patient complained of a peculiar taste in the mouth, tightness of chest, and an intense itching of both hands and feet. Almost instantly she became cyanotic in the face, dyspneic, began to vomit, and collapsed.

Immediate physical examination revealed no measurable blood pressure and no pulse on the radial artery. Patient was cold and perspired profusely. 25 mg. of benadryl®—(betadimethylaminoethyl benzohydryl ether hydrochloride)—and 3 minims of 1:1000 solution of epinephrine were immediately administered intravenuously, patient given oxygen by BLB mask, and after an intravenuous injection of metrazol® was given, patient was brought to the hospital.

On arrival in the hospital, the patient was found to be in a profound coma, blood pressure was unobtainable and pulse on the radial artery thready. Oxygen treatment was continued and plasma transfusion started. Epinephrine i. v. was repeated and 50 mg. of cortisone administered intramuscularly. The general condition seemed to improve somewhat, but patient remained unconscious and blood pressure unobtainable, until an intravenous infusion of 5 per cent glucose in water solution with 4 cc. of levophed® (norepinephrine, Winthrop-Stearns) was started. Ten minutes after the beginning of this infusion, the patient regained consciousness, and the blood pressure reached 60/30 millimeters of mercury.

Laboratory findings: Hyaline, granular and waxy casts as well as an occasional leukocyte, were present in the urinary sediment. No albumin and no sugar were detected in the urine. Blood count revealed marked anisocytosis, 4,150,000 red blood cells, 12.5 Gm. hemoglobin, 13,350 white blood cells with a marked "shift to the left" in the differential count, and no eosinophilia. Reaction to Kline test was negative. The electrocardiogram showed right axis deviation and regular sinus rhythm.

Subsequent treatment consisted of oxygen tent, 50 mg. of cortisone by mouth four times a day, 50 mg. benadryl® by mouth four times a day, and close supervision. Recovery was uneventful. Tightness in the chest as well as respiratory difficulties disappeared within 12 hours after the penicillin injection. The next day, the patient had no complaints except a severe headache which lasted for another 72 hours. The temperature was normal on admission, rose to 100°F. on the second hospital day, but returned to normal on the following day. On November 18, 1952, the patient was free from any complaint or finding which might have been interpreted as sequelae of the described penicillin reaction.

COMMENT

There can be little doubt that the described episode was due to an acute failure of peripheral circulation, the mechanism of which remains unknown. The etiology seems to have been revealed by subjective symptoms voiced by the patient just before she lost consciousness. In a person known to be susceptible to sensitization, itching and sensation of tightness in the chest warrant acceptance of allergic etiology, thus corroborating the diagnosis of anaphylactic shock.

Certain criteria, however, have to be con-

sidered before a causal relationship of the patient's condition and the administration of the suspected drug can be accepted. The disease under treatment should not be known to produce the condition under investigation; and the mechanism of action of the suspected drug, if known, should allow a plausible explanation of the new symptom. Obviously an upper respiratory infection, if severe enough, can be the cause of circulatory collapse, but it is improbable that so severe an infection existed in this ambulatory patient. The abruptness of the onset, without any prodromal symptoms, is another reason for rejection of the underlying respiratory infection as a cause of this acute episode. An intercurrent disease leading to a circulatory collapse could hardly develop in such a short time.

The possibility of a circulatory failure due to an intramuscular injection per se should be considered. The psychic effect of any injection on a psycho-labile person is well known, but may be disregarded in the presented patient, who has undergone many treatments with injections, surgery and x-rays, and to whom the physician and the office were familiar.

The fluid shift in the body which follows a clysis,[4] or an injury to the muscle,[5] could not have been the cause of the collapse, in view of the small amount of fluid injected (1cc.) and the negligible injury sustained by the muscle from the effect of a 22 gauge needle.

The known antigenic properties of penicillin as well as the known clinical picture of anaphylactic shock attributed to penicillin in the reviewed literature, permits the assumption that penicillin was the actual cause of the anaphylactic reaction in our case. As in the case described by Waldbott,[3a] to which the case presented has a striking resemblance, the rapidity of onset of the reaction, and the ominous sign of "taste in the mouth," seem to denote intravenous administration of crystalline procaine penicillin G, also in our case. This assumption is enhanced by the fact of innocuity of an intramuscular injection of the same drug one week earlier. The usual precautions against intravenous administration were definitely handicapped by the use of a small caliber needle, as aspiration through it is not easy and is not sufficient to prevent an inadvertent intravenous injection.

Anti-allergic treatment of anaphylactic shock, using drugs with antihistaminic effect, was successful in the case presented as well as in the reported cases when used. Benadryl,® is definitely indicated in anaphylactic shock because of its potency to alleviate bronchoconstriction due to histamine, and its effect on all smooth muscle, relieving the spasm, but it is not possible to ascertain the importance of cortisone in the case presented. Its anti-allergic effect is well recognized, and it probably has contributed to the success of this treatment.

It is of interest to note, that neither the antihistaminics alone, nor their combination with transfusion of plasma, could restore the blood pressure in the case presented. The blood pressure was gradually restored to normal following an intravenous injection of a solution containing norepinephrine. We dare not decide whether this is a pure coincidence, or is related to the mechanism of the anaphylactic shock. Restoration of a sufficient supply of blood to the brain, was followed by emergence from unconsciousness, heralding the subsequent favorable course. The headache lasting 72 hours should be considered the logical sequel of the temporary and relative anoxia of the brain.

CONCLUSION

The chief principle in treatment of allergies, and prevention of anaphylactic shock is the avoidance of the allergen. An occasional inadvertent intravenous injection is apparently unavoidable, even in most careful hands, but the mishap will be less frequent if the use of small caliber needles for intramuscular injections is discontinued. It seems impracticable to test the sensitivity of every patient in need of penicillin, because of the large number of patients requiring this drug, as well as the relatively insignificant number of penicillin sensitive persons.

However, the "production" of penicillin sensitive persons is in our hands. We join here all the previously quoted authors in pleading for discrimination in the use of penicillin as well as other antibiotics. The duration of drug allergy is unpredictable, may last many years, and may become evident in a fatal anaphylactic shock. The number of penicillin sensitive persons is probably increasing with widening use of this powerful drug. It is, therefore, imperative that the possibility of inducing an anaphylactic shock by an "intramuscular" injection of penicillin be always present in our minds. It should, therefore, be administered in places where treatment of such a condition is practicable, or under the supervision of a physician equipped to handle such an emergency.

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Intramuscular Pentobarbital Sodium for Premedication To Children

JAMES R. JARVIS, M. D.

TO the best of my knowledge this is the first report of the use of pentobarbital sodium solution administered intramuscularly. This report is based on a series of 60 private child patients, personally anesthetized by me, where a stock solution of pentobarbital sodium, combined with hyoscine, was used for preoperative sedation.

The preparation used was Abbott's veterinary nembutal® solution supplied in 100 cc. vials containing 60 mgm. of pentobarbital sodium per cc. dissolved in propylene glycol. This is quite similar to the medical type which is supplied in 20 and 50 cc. vials, containing 50 mgm. per cc. There may be a third form available that I am now trying,* supplied in 1 cc. ampules containing 120 mgm. per cc., thus reducing the total volume needed.

The majority of the operations was for tonsillectomy, though the same dosage schedule was used for other operations such as appendectomy, reduction of fractures, squint, herniorrhaphy, et cetera. The youngest child was two and a half years old, the oldest 14 years of age. Various anesthetic agents used, after premedication with pentobarbital sodium and hyoscine, were: vinethene,® ether, cyclopropane, and chloroform—the latter for reduction of fractures where use of the fluoroscope created a spark hazard. Nitrous oxide was not used though I do not see any contraindication.

The pentobarbital sodium and hyoscine were mixed in the same 2 cc. syringe keeping the total volume to 1 to 1½ cc. and given with a No. 22 1½-inch needle deep in the gluteal muscle. The anesthetic began from one-half hour to two and one-half hours later. It was found that the lapsed time from injection to induction was best from one hour to one and one-fourth hours, though satisfactory phase was maintained from 45 minutes to one and one-half hours, and some effect still present at end of a two hour period.

In clinically comparing the sedative effect of intramuscular pentobarbital sodium with hyoscine, to premedications with rectal pentothal® or rectal avertin,® I feel the pentobarbital sodium-hyoscine is far superior. When giving medication by rectum there is always the uncertainty of retaining the medication and rate of absorption, varying its effectiveness much more so than that seen with the pentobarbital sodium intramuscularly. The period of usefulness, including postoperative sedation, is prolonged with pentobarbital sodium, while quite short with pentothal.® As for avertin,® pentobarbital sodium intramuscularly has the advantage of little or no respiratory depression, at least as observed in this small series, while it is frequently present with avertin,® requiring extra nursing care.

The parents of all children were present when the child was returned from surgery as we do not have a recovery room. The parents were sent a questionnaire and returned the form, answering a number of questions. To a great extent the evaluation of the pentobarbital sodium with hyoscine for premedication is based upon their answers. A tabulation of the study is presented.

Presented before the Ohio Anesthesia Society at Youngstown, September 19, 1952.

* Furnished by Abbott Laboratories.

The Author

● **Dr. Jarvis, Van Wert, Ohio, is a member of the American College of Anesthesiologists; on staff Van Wert County Hospital, Van Wert, and Lima Memorial Hospital, Lima.**

SEDATIVE EFFECT

Sedative effect was found to be as follows:

1. 60% of the children were asleep and stayed asleep until going to surgery and had no recollection whatever of leaving their beds.
2. 30% slept more or less before surgery and had but a hazy recollection of the operting room.
3. 6% remembered the induction but were calm and unafraid.
4. 4% were excited and afraid of the induction, requiring restraint.

POSTOPERATIVE SLEEPING

One of the questions asked the parents was relative to the length of time their child slept after surgery. Based on the parents reports this varied from one-half to eight hours in duration. The majority slept from three to five hours. Inasmuch as nearly all the tonsil patients, which comprised 40 of the 60 cases, had a return of the gag reflex before leaving the operating room, it is reasonable to assume that most of the sleeping postoperatively was due to the pentobarbital sodium and not the anesthetic agent; likewise, these children could be aroused but would immediately go back to sleep.

POSTOPERATIVE VOMITING

It is felt that the amount of postoperative vomiting was considerably reduced though no

control cases were tabulated. In this series of 40 tonsillectomies, the parents reported the following:

No vomiting in 75%
Slight vomiting in 20%
Moderate vomiting in 5%
Excessive vomiting—0.

PAIN

As for pain at the site of and time of injection:

80% reported no pain
10% reported slight pain
10% reported moderate pain
0 pain was reported to continue after surgery.

Only one child complained of a sensation disturbance later. This was an area of hyperasthesia the size of a half-dollar over the biceps muscle. This was the only patient to whom the administration was given other than deep in the gluteal region, and it is possible that the nurse did not actually administer it into the muscle, but deep subcutaneously. When rechecked three weeks later the condition had completely cleared.

LARYNGOSPASM REDUCED

There were no cases of abscess formation, none of respiratory depression. It is felt that there was also considerable reduction of laryngospasm associated with induction, only one patient out of the 60 showing more than mild transitory spasm and that one apparently was due to ether vapor.

RECOMMENDED DOSAGE

The dosage used was varied up and down so that two to four different size doses were used in each of the age brackets, and the table presented is the one considered the best; the one that will give a basal analgesia associated with a high percentage of amnesia. Likewise, the hyoscine dosage was varied and though may seem high to some, it was found clinically to be the best. Interestingly enough, by this trial and error method it was found it required a basal dose of 10 to 15 mgm. of pentobarbital sodium, plus 5 more mgm. for each year of age. The following is the full recommended dosage chart.

DOSAGE SCHEDULE I. M.

Age	Nembutal® mgms.	Hyoscine mgms.	Hyoscine grs.
3	25-30	0.2	1/300
4	30-35	0.2	1/300
5	35-40	0.2	1/300
6	40-45	0.24	1/250
7	45-50	0.24	1/250
8	50-55	0.24	1/250
9	55-60	0.3	1/200
10	60-65	0.3	1/200
11	65-70	0.3	1/200
12	70-75	0.4	1/150
13	75-80	0.4	1/150
14	80	0.4	1/150

COMMENT

As mentioned before, this entire work is based on clinical evaluation. One interesting point should be studied by those with proper facilities to do so, and that is what happens to the pentobarbital sodium solution in the muscle. Several research workers have showed the propylene glycol to be miscible and non-toxic. At least theoretically the pentobarbital sodium should precipitate in muscle as the *p*H is slightly on the alkaline side. The prolonged action, up to eight hours, may be explained on the premise that the pentobarbital sodium does precipitate and is slower to be absorbed. If so, this would be a safety factor to prevent respiratory depression, and might prove to be a safe method of giving sodium pentobarbital for other purposes in addition to preoperative sedation. The fact that in over 60 patients it was used without sequelae, and with the excellent results here reported, warrants further investigation into the use of intramuscularly administered pentobarbital sodium.

CONCLUSIONS

1. Intramuscular administration to children of pentobarbital sodium combined with hyoscine is safe and advantageous in the dosages recommended for preoperative sedation.

2. Certain advantages of intramuscularly administered pentobarbital sodium over rectal premedications are mentioned.

Treatment of Angina Pectoris With Nitroglycerine

Nitroglycerine is a drug of great value in the treatment of angina pectoris, and yet we often must urge the patient to use it. Unfortunately too many patients have the impression that there is something habituating about this drug, or they are fearful that if they use it there may be a time a few months or years hence when the need is greater and the nitroglycerine will no longer be effective. It is my belief that if nitroglycerine is really effective in any individual it will always be so, and if the medication fails, it does so because the underlying disorder has grown worse.

In many instances the patient can be advised to use nitroglycerine prophylactically, that is, he can use it before he performs an effort which he knows is likely to produce pain. However, some judgment must be exercised in this regard lest the patient attempt a considerably greater effort than he should really undertake. When nitroglycerine is used in doses of 0.3 mg. (gr. 1/200), the patient usually has relief from his pain without uncomfortable aching and throbbing developing in the head which is often a disagreeable side effect of larger doses.—Francis F. Rosenbaum, M. D., Milwaukee; *Wisconsin Med. J.*, 51:990, October, 1952.

The Emergency Room Treatment of the Comatose Patient
A Review of One-Hundred Cases

L. V. PHILLIPS, M. D., and H. E. MAY, M. D.

PROMPT differential diagnosis of coma may tax the skill of the most experienced physician. Yet it is the novice house officer on duty in the emergency room of a city hospital who is most frequently confronted with this problem. On the speed and accuracy of his diagnosis may hinge the life of the comatose patient.

It may be instructive to review a series of 100 such cases admitted to the emergency room of Peoples Hospital* during a 17-month period beginning in January, 1951. Included are those patients who were completely comatose or responded only slightly to painful stimuli. Those sent in directly to the hospital wards by attending physicians were not included because in such cases the diagnosis was less obscure due to previous examination and knowledge of the case history.

Most of the patients in this series were first seen by the authors. From this first-hand experience an attempt will be made to point out the more frequent errors in diagnosis or in omission of diagnostic procedures that might have been of value. All of these patients were admitted to the hospital wards for study and treatment. The fact that 38 of this series died would indicate the gravity of the problems faced.

REVIEW OF CASES

Table 1 is a classification of these cases into general groups.

It is to be noted that in this series of 100 cases of coma, vascular disease comprises the largest group—a total of 47. Of these, 37 were cerebro-vascular lesions and 10 cardio vascular disease. Concussion was the cause of coma in 12 cases. Since such head injury is frequently the result of alcoholism, a real danger exists in the failure to recognize serious head injury in a patient who is brought in "drunk." Barbiturate poisoning was as frequent as alcoholism as a cause of coma in this series and fortunately no deaths occurred. Of interest is the predominence of insulin shock over diabetic coma. In the four undiagnosed cases listed, recovery occurred without adequate proof of the cause of coma.

This gross mortality of 38 per cent is high but is made up chiefly of these patients whose comatose state was due to vascular disease. In this group of 47 cases there were 34 deaths, a mortality of approximately 72 per cent. In the remaining 53 cases there were only four deaths, a mortality of less than 8 per cent.

Submitted October 8, 1952.

*Medical Service, Peoples Hospital, Akron, Ohio. Under direction of Dr. R. F. Jukes, Chief of the Medical Service.

The Authors

● Dr. Phillips, Akron, Ohio, former resident at Peoples Hospital, Akron, is now in practice (internal medicine).

● Dr. May, Barberton, Ohio, now practicing internal medicine, was formerly resident at Peoples Hospital, Akron.

ANALYSIS OF DIAGNOSTIC ERRORS

Perhaps the most fruitful facet of this study is an analysis of the errors made in emergency room diagnosis. The initial diagnosis made in the emergency room was correct in 75 per cent of the cases. The four cases undiagnosed as to the cause of coma were discharged as recovered after adequate observation. In various types of "functional" syncope a detailed and accurate history may provide the only clue.

The final diagnosis usually resulted from study in the hospital wards after admission or by autopsy. Postmortem examination was obtained in 24 cases or 63 per cent of those who died. The average age of the patients who died was 64, while that of those who survived was 45 years.

One major diagnostic error lay in the differentiation of the various types of vascular accidents. Cerebral hemorrhage and cerebral thrombosis were frequently confused. This brings up the debatable value of routine spinal puncture in this group of cases. Certainly the diagnosis could be clarified earlier in many cases and should have been done more frequently in this group. Its routine use prior to qualified neurosurgical consultation is very questionable. Such consultation should be obtained promptly in all suspected head injuries.

The comatose patient with advanced pulmonary edema may be suffering from coronary occlusion, ruptured aortic aneurism, uremia or acute heart failure of various types. A direct writing electrocardiograph should be available to the emergency room and the house officer able to take and interpret the tracing. In the shock state of coronary thrombosis, prompt use of one of the pressor amines may be life-saving.

The laboratory should be used freely in doubtful cases for obtaining blood levels of alcohol,

barbiturate and bromide. These procedures would have eliminated some of our errors in diagnosis. Simple testing equipment for sugar and acetone in the urine should be kept in the emergency room and was proved of value for prompt testing in suspected diabetics.

ROUTINE EXAMINATION PROCEDURES

It might be well to outline here a general routine of procedure for the house officer who is confronted with a comatose patient in the hospital emergency room. Often a history, if available, may be obtained from the family or accompanying person as the patient is being placed upon the examining table. Particular

TABLE 1
Classification of Cases

		Number of Cases	Deaths
Cerebrovascular Lesions		37	27
(a) Cerebral hemorrhage	17		
(b) Cerebral thrombosis	15		
(c) Subarachnoid hemorrhage	3		
(d) Encelopathy	2		
Concussion		12	2
Drug Poisoning		11	
(a) Barbiturate	8		
(b) Other Drugs	3		
Heart Disease		10	7
(a) Coronary occlusion	2		
(b) Coronary insufficiency	2		
(c) Pulmonary edema	2		
(d) Adams-Stokes Syndrome	2		
(e) Ruptured Aortic aneurism	1		
(f) Chronic Cor Pulmonale	1		
Alcoholism		8	
Insulin Shock		6	
Epilepsy		4	
Hysteria		3	
Diabetic Coma		1	1
Miscellaneous		8	
(a) Undiagnosed	4		
(b) Glioblastoma of the Brain	1		1
(c) Metastatic carcinoma	1		
(d) Stab wound of chest	1		
(e) Gastroenteritis	1		
Total number of cases		**100**	**38**

reference should be made to recent illnesses, injuries, epilepsy, alcoholism, hypertension, previous strokes, diabetes, taking of drugs, heart disease and nervous disorders.

GENERAL APPEARANCE

As the patient is being disrobed one should note the appearance of the clothing; look for blood, incontinence or other stains. The general appearance of the patient should be observed. Lack of motion of one or more extremities or facial weakness may suggest a cerebral vascular accident. Blood, lacerations or bony deformities would suggest trauma as the etiology. A pale, moist skin with fast pulse would indicate hypoglycemia or hemorrhage, either external or internal, while a pink appearance might be due to carbon-monoxide poisoning. The odor of the breath may indicate alcoholism, diabetes or uremia. Multiple pin-point scars from injections are often seen in diabetics or dope addicts.

Following the preliminary appraisal a more systematic and detailed examination of the patient is made. Application of painful stimuli will frequently help to differentiate coma from stupor or hysteria. Rectal temperature, pulse, blood pressure and respirations are carefully taken.

HEAD EXAMINATION

The head is next examined. Inspection and palpation may reveal lacerations or depressed fractures. Unilateral facial weakness, nystagmus, strabismus or other ocular abnormalities suggest a cerebral lesion. Equality of the pupils and their reaction to light should be noted. Dilated pupils are frequently found in alcoholism, cerebral vascular accidents or carbon-monoxide poisoning, while pin-point pupils are usually associated with pontine hemorrhage or opium poisoning.

Ophthalmoscopic study should exclude papilledema and diabetic or hypertensive retinitis. Not to be omitted is examination of the auditory canal for blood, pus or spinal fluid. Burns of the lips or mucous membrane of the mouth are usually present in corrosive poisoning, while a bleeding or scarred tongue strongly suggests epilepsy. The neck should be tested for mobility and rigidity. A stiff neck most frequently is associated with meningeal irritation or subarachnoid hemorrhage.

CARDIOVASCULAR SURVEY

Cardiovascular survey should include careful examination of the heart, the pulse rate and blood pressure. Hypertension would favor the presence of a cerebral vascular accident, while hypotension leads one to look for conditions which result in shock. The possibility that an abnormal finding may be wholly unrelated to the primary disorder must not be overlooked. Adams-Stokes syndrome should be considered if a slow pulse is present. Irregular rhythm such as premature beats or auricular fibrillation may reflect primary heart disease or suggest the possibility of emboli from mural thrombi or vegetations on the heart valves. An aortic diastolic murmur should alert the examiner to seek for evidence of neurovascular lues. Examination of the chest should exclude trauma, signs of congestive failure, pneumonia, pulmonary embolus and rupture of an aortic aneurism.

The abdomen is next examined for rigidity or masses. A rigid abdomen usually denotes spontaneous or traumatic rupture of a vessel, the intestine or other organs.

The extremities should be individually examined

and manipulated. A flacid limb or bony deformity will often give the first clue to the correct diagnosis. As in any physical examination the color of the nail beds should be noted.

A careful, complete neurological examination is always mandatory. The diagnosis of cerebral vascular accidents, brain tumors or infectious diseases of the brain can be strongly suspected or established by this examination.

LABORATORY PROCEDURES

Usually at this time, one has some idea of the cause of coma but if physical findings are essentially negative one must refer to laboratory procedures. The laboratory, however, is called upon only after all possible history has been obtained and the physical examination completed. The most helpful tests are: complete blood count, spinal fluid examination, urinalysis, blood urea nitrogen, blood sugar, CO_2 combining power, and blood or urine examination for barbiturates or other suspected drugs. A high blood urea nitrogen is found in uremia. A moderately elevated blood sugar (250 or less) must be interpreted with caution as many comatose patients who are not diabetics will show some hyperglycemia. The urine of a patient in diabetic coma would show evidence of glucosuria, acetone and diacetic acid.

The lumbar puncture is valuable in differentiating whether or not the disease process directly involves the brain. In our series of cases it has rarely been necessary to have emergency x-rays taken of the skull. The electrocardiogram is helpful in cases of coronary occlusion or of Adams-Stokes syndrome.

SUMMARY AND CONCLUSIONS

1. A series of 100 consecutive cases of coma admitted to a hospital emergency room is presented.
2. Vascular disease accounted for 47 with an attendant mortality rate of 72 per cent.
3. Other causes of coma comprising 53 cases resulted in a mortality of less than 8 per cent in this group.
4. A systematic routine of examination and appropriate laboratory studies is outlined.
5. Since young and inexperienced house officers are often assigned to emergency room duty, the cooperation of the attending hospital staff physicians in setting up a specific routine of diagnostic approach should be encouraged.

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Arterial Hypertension

Essential hypertension often requires little treatment because the vascular disease associated with it advances at so slow a pace. If, on the contrary, it accelerates, as in the severe or malignant phase, then drastic treatment is requisite. Toxemia of pregnancy may also be benefited.

Current treatment is based on the view that a decrease of arterial pressure to or towards normal levels is desirable and beneficial. There seems to be much truth in this hypothesis. It does not preclude the possibility that, in addition, treatment of the diseased blood vessels should not be thought of. But as matters now stand, with the possible exception of the use of pyrogens, treatment of blood vessel disease is beyond the physician's capability.

We pointed out in 1937 that lowering of blood pressure as a result of sympathectomy caused definite improvement in both the electrocardiogram and size of the heart. This was later confirmed by many investigators. There is now little doubt that many of the signs of cardiac strain disappear when arterial pressure is reduced.

Thus it can be agreed that when the vascular disease, as exemplified in the eyegrounds, heart and kidneys, is advancing by increments measurable within periods of a year or two, lowering of the average arterial blood pressure is desirable. There are several ways of doing this. . . .

So far no one has found a single remedy which lowers blood pressure in all patients with essential or malignant hypertension. During the past 25 years we have repeatedly observed that about 20 to 30 per cent of patients respond by a lowering of arterial pressure to normal, to such measures as sympathectomy, drastic low-salt diet or even sedatives and psychological readjustment. But over all this time, an objective method has not been found for selecting patients who will respond to one or other treatment. If, for example, patients could be properly selected so that 95 per cent would exhibit an excellent result from sympathectomy instead of the usual 20 per cent, then there would be little question as to the place of sympathectomy in the treatment of the specific cases of hypertension.

Despite the many suggested methods for selection such as the cold pressor test, the sodium Amytal test, the posture test, etc., none has proved satisfactory. Unfortunately, with the newer drugs there also is no method for selection. An adequate trial period is the only current way to determine whether the patient will or will not respond.—Irvine H. Page, M.D., Cleveland, *J. M. A. Georgia*, 42:78, February, 1953.

A Special Study of Endemic Goiter in Mexico and the Central and Latin American Countries*

O. P. KIMBALL, M. D.

THE opportunity to make this special study of endemic goiter, through Mexico, Central American and the Latin American countries, was accepted with appreciation and gratitude. For me it was further and more comprehensive research of the study I have been making in the United States for over 30 years.

Endemic goiter is one of the oldest, most insidious, and far-reaching food-deficiency diseases known. In contrast, it is the easiest known disease to prevent.

Endemic goiter and its sequelae is mentioned in the earliest records of every South American State. Undoubtedly it existed among the Indians of the mountainous areas for centuries and was a definite factor in their civilization.

Last week, while reviewing the goiter problem in Lima, a member of the Ministry of Health stated that they had a record dating back to 1800 when one of their great leaders discussed this disease and thought something should be done about it. The doctor reflected, "To date nothing has been done about it." That sentence is the key to this meeting—we can, and must do something about it.

For centuries the causes of this disease have been linked to the water supply. Three centuries ago some of our earliest observers thought it was due to something in the water, such as an excessive amount of calcium or limestone. Professor Chatin, a French chemist, wrote several papers on endemic goiter between 1850 and 1854, stating that the etiology is a deficiency of iodine. However, the first correlated scientific data on the relation of iodine to endemic goiter was given to us by Dr. David Marine in his experimental studies, from 1905 to 1915, of the physiology and chemistry of the thyroid gland. Dr. Marine found that the normal function of the thyroid was entirely dependent on iodine.

RELATION OF IODINE TO GOITER

From his experimental data he stated conclusively that:

(1) as long as the thyroid contains **one** milligram or more of iodine per gram of thyroid, no cellular changes or goiter formation will take place;

(2) as soon as the iodine content falls below **one** milligram of iodine per gram of thyroid, cellular hyperplasia and hypertrophy, or goiter formation, begins. But as long as the iodine content remains at or above **one** milligram of iodine per gram of thyroid, experimentally you cannot produce these cellular changes, or goiter.

Marine summarized that, "Goiter is an overwork hypertrophy of the thyroid gland in an attempt to produce its hormone, thyroxin, without the essential element iodine."

Every study on the prevention of endemic goiter, which has been productive, was based on the fact that this disease is due entirely to a deficiency of food iodine. Time will not permit a discussion or even mention of the numerous theories and hypotheses contrary to this simple statement, but there is no scientific data showing that goiter can be prevented by any other method than with sufficient iodine intake.

PREVENTION EASY

For more than 30 years these statements have been verified by the prevention of goiter in man. This work has been so widespread and is so well known that no detailed report is warranted here. Each and every report, based on scientific data, emphasizes the truth of Marine's early teaching, that "Endemic Goiter is the Easiest Known Disease to Prevent."

Another equally important fact has been demonstrated by the accumulated data on the use of iodized salt over the past 25 years, namely, there is no harmful effect to anyone by this method of giving food iodine.

The present study began with a review of the progress on goiter prevention in Mexico. I had known of Dr. Herbert Stacpoole and his work. In fact, we had corresponded and exchanged views on goiter and its prevention by the use of iodized salt for over 20 years. During this time he has made examinations of many villages and cities as well as representative districts in eight states in Central Mexico. He made a detailed study of 667 municipalities.

INCIDENCE

The eight states comprising this study have **a** total population of eight and two-thirds million. The total of individual examinations was one

*Presented at the Brazil Conference on Nutrition held under the auspices of the Food and Agriculture Organization of the United Nations, June, 1950.

The Author

● **Dr. Kimball, Cleveland, who is chief of the medical staff at Doctors Clinic, Cleveland, is consultant to the World Health Organization on endemic goiter.**

million. The incidence of goiter throughout these eight states averaged approximately 25 per cent, while in many of the Indian villages the incidence of goiter, deaf-mutism, cretinism, and feeble-mindedness is appalling. Frequently 80 to 90 per cent of all the inhabitants have goiter. Evidence of degeneration, both physical and mental, is clearly seen in every village.

SEQUELAE

In Guatemala we spent ten days studying the inhabitants of ten mountain villages. This study was made in cooperation with the National Institute of Nutrition, a division of the Pan-American Sanitary Commission. Stated briefly, I have never encountered so much evidence of the degeneration produced by endemic goiter. Feeble-mindedness and deaf-mutism were very common. We saw few cases of severe cretinism because such a person could not survive the rugged life of these people. This same condition was found in Ecuador, Colombia, and Peru.

In Lima, Dr. Ponce de Leon reported 80 per cent of the school children goiterous in one village on Lake Titicaca. In some of the mountain villages north of Lima he had found a high per cent of extremely large goiters with much of the degeneration that is seen in severe endemic goiter districts. In a village high in the Andes, in the northwestern part of the country, the villagers boast of having the largest goiters in the world.

Endemic goiter, with its sequelae, is reported in every state of South America, with the exception of Chile and Uruguay, and this is due to their geographical limitations. In no country do we find many cases of endemic goiter along the seacoast.

IODIZED (ENRICHED) SALT RECOMMENDED

Without further discussion of goiter, let us move directly to the task of meeting this food-deficiency. We have studied every method of increasing the iodine intake and, after years of study and experimentation, we are convinced that the cheapest, safest, and most efficient way of assuring an adequate intake of food iodine is by the general and continuous use of iodized salt. I would advise that the term "iodized" not be used. It gives the impression that the salt is medicated, and there is a natural opposition in most of us against the idea of someone putting medicine in our food. In Brazil it has been recommended that they use the term "enriched" salt (sal enricquecido).

There is in each country I have visited a feeling that it would be sufficient to improve just a part of the salt. In Mexico they advise this enriched salt only where the incidence of goiter is 35 per cent or more. Guatemala hopes to have this improved salt for every section. Colombia and Ecuador also need extra food iodine in every state. In Peru one of the officials in the Ministry of Health admitted that they should have this improved salt for one locality in the southeastern part of the country and in the northeast, in a village high in the Andes.

In Brazil it has been repeated to me many times that only the inlands or mountainous areas needed this protection against iodine deficiency. I have seen many goiters while on the busy streets of Rio, and would estimate that a careful survey of all the school children of that city would show an incidence of goiter of from 5 to 10 per cent. In 1948 a survey was made of the children in the village of Aimores, on the River Doce, by Social-Educational-Sanitary Program and one-third of the children had goiter and one-third showed physical and mental retardation. This village is less than 100 miles from the sea. I am also informed by Dr. Oswaldo Silva, Director of the Special Health Service of Araraquara, Sao Paulo, that surveys made of the school children in that city reveal that 40 per cent have goiter.

Brazil has made at least one attempt to make and use iodized salt. During the time Professor Manuel Ferreira was Director of a Foundation for the Development of the Central Areas of Brazil, this Foundation experimented with iodized salt and actually used it in the State of Goiaz. Unfortunately after 1946 this work was stopped.

Endemic goiter represents a relative deficiency of food iodine, and in general, this deficiency is growing worse with each generation. To me it is all important that we start meeting this deficiency in its entirety. Only good nutrition with normal growth and development can result from an adequate intake of food iodine, so why restrict its use to the community where congenital defects and degeneration are obvious?

SHOULD BE ONE STANDARD ENRICHED SALT

The only answer is that it will save the cost of adding iodine to half or one-third of the salt. This is true, but it also costs more to manufacture and handle two kinds of salt. What could be saved by making only one grade of salt would almost pay for the extra iodine. Again, it is much more difficult to get legislation to iodize part of the salt than all of it. It costs more to enforce this division of food salt than to have only one standard salt for the entire state. There can be further cost reductions, and at the same time offer a more stable product, by the use of moisture-proof paper bags, either the 100-pound bag for restaurants, or the 10-pound bags for the homes.

I strongly urge each country where endemic goiter is present to use only food salt to which iodine has been added, in the proportion of one part potassium iodide to 10,000 parts of salt.

CANADA'S LAW

The Canadian Government has given us a splendid example of such legislation in their brief

but effective law which was passed last year and is now in effect. Their law is as follows: *"No salt shall be sold for food or table use unless it contains iodine in the proportion of one part of potassium iodide to ten thousand parts of salt."* In one generation this will eradicate all endemic goiter and its degeneracies, except those congenital defects dating back to the days of iodine deficiency. There will be no harm to anyone by the continuous and general use of this improved salt.

RECOMMENDATIONS

We must not talk for another 150 years. We should act now. Therefore I propose that this World Health Organization make recommendations to each nation of South America, Central America, and Mexico, suggesting that an organized effort be made to prevent endemic goiter. It should be emphasized that this food-deficiency disease is so widespread that it is essential that corrective measures apply throughout each country where goiter is endemic, and be planned so that it will be continued indefinitely.

The deficiency in this disease is iodine, and any food rich in iodine will promptly correct the deficiency and prevent the disease.

Common salt is used by everyone and in approximately the same amounts. Salt can be so enriched by the addition of potassium iodide in the amount of one part iodide to 10,000 parts of salt. In this amount each individual will get about one milligram of potassium iodide daily. This amount will meet the physiological demand in most instances but not all of them. In exceptional cases of growth, sickness, or pregnancy, this amount may need to be increased, but such cases are few.

This Organization can promise each country full and complete instructions on how to prepare enriched salt. The cost of preparing and maintaining this enriched food will be much less than the care of the feebleminded, deaf mutes, cretins, and other persons with toxic goiter. These are the fruits of endemic goiter, and the fundamental condition grows worse with each generation.

RESPONSIBILITY OF GOVERNMENT AND BUSINESS

The science of this preventive measure is no longer questioned. Every medical science organization now advises the prevention of endemic goiter. Now it is the responsibility of government and business to correct this food deficiency. It is the duty and responsibility of this Organization to so focus the attention of each government on this important problem so that soon no government will tolerate the stigma of "Endemic Goiter" within its country.

Infantile Diarrhea—Fluid and electrolyte replacement is the key to promoting recovery in infantile diarrhea.—D. C. Darrow, M. D., *Pediatrics*, 9:519, May, 1952.

KEEPING UP WITH MEDICINE

• SINCE under the usual conditions of life the electrocardiogram remains the same for each individual and changes very little from decade to decade, it is important for the patient to have a normal control tracing on file to be taken at his next periodic health examination.

* * *

• ADDICTION to barbiturates is now considered more dangerous than morphine addiction. Yet 8 million sleeping pills are sold in the United States every day.

* * *

• VAGUE nondescript cramping or other abdominal discomforts often respond to the administration of 25 mgms. of benadryl® three times daily before meals.

* * *

• WHEN cortisone completely blocks the formation of immune bodies then the basic immunological reaction in the tissues which cause the allergic response cannot occur.

* * *

• FLUORINE in rock phosphate or in dusts from nearby industrial plants have often been reported as doing damage to cattle.

* * *

• WITH patients on cortisone, it is extremely important to treat promptly recurrent episodes of respiratory tract infection.

* * *

• SMALL amounts of alteration in serum potassium may be fatal.

* * *

• THE ABILITY to control antibody production by regulating vitamin intake should be a useful tool in unraveling the problem of how antibodies are made.

* * *

• THEY are now investigating in both the United States and England the nature of a factor in milk which is protective against infections with certain virus.

* * *

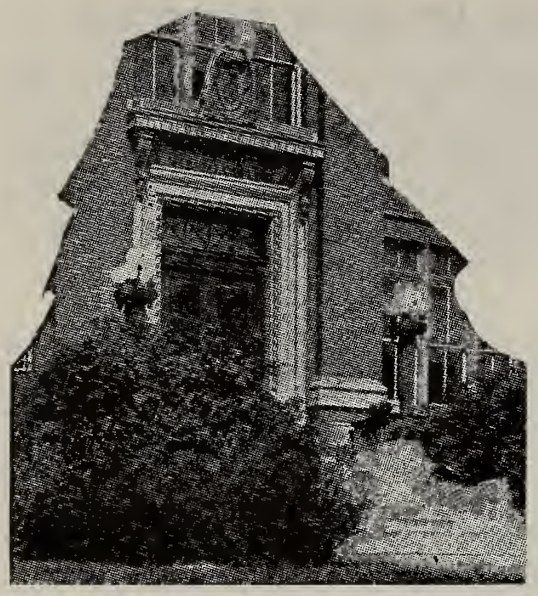
• ONE of the recent observations that has interested us is that alcoholics, who as a rule have a proportionately lower concentration of cholinesterase concentration in their serum than do normal persons, also seldom have hypertension.

* * *

• DIPHTHERIA today shows evidence of an increased incidence with a shift to the older age groups on a higher mortality and complication rate.

* * *

• A DIET varied in food intake at each meal, properly prepared and consumed in such quantities as obtain and maintain a desirable weight, will generally be a balanced diet.—J. F.



A Case Record

From The Cincinnati General Hospital

Edited Under the Auspices of the Ohio Society of Pathologists

Robert Ritterhoff, M. D., President

Presented by Robert M. Woolford, M. D., and Frank P. Cleveland, M. D. Edited by E. A. Gall, M. D.

PRESENTATION OF CASE

ON her final admission this 73 year old white woman entered the hospital on November 29 complaining of sudden hematemesis and melena and died seven hours after entry.

For six years until the preceding January the patient had attended the Gastric Clinic, where she received treatment for the relief of symptoms ascribed to chronic gallbladder disease. During this period roentgen studies of the chest revealed a normal appearance except for slight diffuse increase in the bronchial markings and an area of linear fibrosis in the right second interspace. Examination of the gallbladder showed evidence of poor function and multiple calculi. A Kahn test of the blood was positive and the patient was treated with mercurials and bismuth. As the liver was enlarged arsenic compounds were avoided. An electrocardiogram showed left axis deviation and slurred QRS complexes in all leads.

Four years before her final entry cervical cellulitis with persistent enlargement of a submandibular node followed the extraction of a left lower molar tooth. Two months later this node was incised and cultures of the purulent material released yielded Staphylococcus aureus. A biopsy at the time of incision showed only inflammation. The wound drained for about two months and search for fungus infection was unsuccessful. Roentgen films revealed evidence of osteomyelitis of the left mandible.

About two years later a firm, non-tender superficial lymph node appeared in the left side of the neck. Roentgenogram showed no evidence of calcification in the region of the node, and a biopsy exhibited only chronic inflammation. Within six weeks many bean-sized nodes had appeared in the left anterior cervical region. The patient was seen on several occasions during the succeeding months because of indigestion, and roentgen studies revealed only continued evidence of gallbladder disease with stone. A barium enema showed a normal colon and ileum except for a few diverticula in the colon. She was not seen then for a period of ten months.

When she returned to the Clinic one year before her final hospital admission there were large nodes in both submaxillary and suboccipital regions with greater prominence on the right. These had appeared six months earlier and had grown progressively larger. Recently there had been a persistent sore throat, some difficulty in swallowing and increasing weakness. She was therefore admitted on October 25 for further study and biopsy.

Of interest in the past was the history that at the age of 41 she was admitted to a sanitarium for treatment of pulmonary tuberculosis and was hospitalized intermittently for the next four years. Twelve years later an excised fistula in ano was said to have shown tuberculosis. At the age of 32 bilateral salpingo-oophorectomy had been done.

Physical Examination: The patient was well developed and nourished but pallid, weak and chronically ill. There was generalized lymph node enlargement and the nodes were firm, movable and slightly tender. The right tonsil was also enlarged. Temperature, 99°F. The heart was not enlarged, the rhythm was regular, and there was a soft systolic murmur audible at the apex and at the aortic area. Pulse, 75 per minute; blood pressure, 140/70. The chest had a barrel-like configuration and a few inconstant rales were audible. Respirations, 24 per minute. The liver extended three fingerbreadths beneath

the costal margin and there was tenderness over the gallbladder area. On deep inspiration the spleen was palpable one finger breadth below the left costal margin. The remainder of the examination was not revealing.

Laboratory Findings: Red cells of the blood numbered 3.8 million with 11 Gm. of hemoglobin; white cells numbered 10,350 with 64 per cent neutrophils, 24 per cent lymphocytes, 4 per cent eosinophils, and 8 per cent monocytes. The urine was normal. A Kahn test of the blood was negative. The blood urea nitrogen was 14 milligrams.

Roentgen Studies: A chest film showed no change from the previous findings. A plain film of the abdomen exhibited moderate enlargement of both liver and spleen. This was in contrast to earlier films.

Hospital Course: Biopsy specimen was taken of a cervical lymph node and the pathologist's report was "non-lipoid histiocytosis," the section showing a peculiar overgrowth of mature but bizarre histiocytes. The patient was discharged to receive roentgen therapy in the Tumor Clinic. She was treated only once (November 17). Following discharge she suffered from anorexia, repeated emesis, weight loss, sore mouth and weakness. On the morning of the final admission (November 29) she suddenly felt weak and nauseated, vomited a considerable amount of blood and passed several black stools. It was thought that she fainted at that time, but at the time of examination she was restless, apprehensive and unable to give a coherent story.

Examination showed her to be acutely ill, pale and dyspneic. The generalized lymph node enlargement had remained unchanged. Temperature, 101°F. The findings in the chest were as previously noted. Pulse, 100; respirations, 30; blood pressure, 94/50. The abdomen was now protuberant and a fluid wave was questionably elicited. The liver and spleen were as before.

The red cell count was 3.3 million with 9.0 Gm. of hemoglobin (after transfusion of 1500 cc. of blood). The white cells numbered 26,700 with 35 per cent neutrophils, 17 per cent lymphocytes, 15 per cent monocytes, and the remainder were immature forms of both red and white cell series. The stool was grossly bloody and the urine showed only a trace of albumin. The blood urea nitrogen was 50 mg. per 100 cc.

The patient was treated supportively, receiving 4 units of blood, but never entirely recovered from shock. She vomited a small amount of blood, some of which was apparently aspirated, and died seven hours after entry.

CLINICAL DISCUSSION

DR. ROBERT M. WOOLFORD: We have a story of chronic gallbladder disease and very moderate treatment for syphilis. The lymph node drained four years ago and the osteomyelitis of the mandible evidently subsided, since there is no further mention of them.

The lymph node noticed a year ago is probably a different one since it is said to have "appeared." Either the other nodes appearing later are a separate process or the original impression was in error. The history of previous tuberculosis just complicates the picture.

The physical examination lists nothing specific except a large liver and spleen. The laboratory data reveal a slight anemia and a mildly elevated white cell count.

The second biopsy is listed as "non-lipoid histiocytosis," which means "all things to all men." Evidently to the clinicians it meant tumor, since she was given x-ray treatment.

On her final admission both the history and findings are those of massive bleeding. The bleeding could be on the basis of a separate condition such as painless gastric ulcer, but bleeding from this area is common in the lymphoma group, so one diagnosis will probably be sufficient. We know that the last differential count of the blood cells showed 33 per cent young forms, but it would certainly be helpful to know how many of them were young red cells.

The limits of the phrase "non-lipoid histiocytosis" vary widely and about all this term tells us is that there is "an overgrowth of histiocytes," as mentioned in the protocol. With this statement, plus a shower of young forms in the blood stream, a large liver and spleen, large lymph nodes and bleeding from the alimentary tract, one of the lymphomata seems quite likely.

At this University the only lymphoma classification which I have courage to mention is that of Gall and Mallory,[1] and their terminology is widely accepted. Of this grouping, clasmatocytic lymphoma seems to fit the requirements best. It is a tumor of histiocytes and may have immature forms in the blood stream although this manifestation is not very common. The intestinal bleeding would be quite consistent. I have no differential diagnosis to discuss since we have biopsy material pointing to this category.

CLINICAL DIAGNOSIS

1. Clasmatocytic lymphoma.
2. Massive gastrointestinal bleeding secondary to lymphomatous involvement of the stomach.
3. Chronic cholecystitis and cholelithiasis.

CLINICAL DISCUSSION

DR. RICHARD W. VILTER: One of our students said this morning that all that was necessary in a case of this nature was to determine if the patient had lymphoma. He said that the determination of the cell type was of academic interest only. With this statement I wish to disagree. The type of lymphoma is indeed important since

we now have different methods of therapy and different prognostic implications for the various forms of the disease.

DR. MARION A. BLANKENHORN: Why weren't hepatomegaly and splenomegaly mentioned in the final diagnosis on the ward?

DR. RICHARD H. WESCOTT: We considered them simply manifestations of the underlying disease.

DR. BENJAMIN FELSON: What did the pathologist mean by the term "non-lipoid histiocytosis"?

DR. EDWARD A. GALL: He was using it in a descriptive fashion and not necessarily to indicate a clinical entity. If one reviews the literature relating to this expression one may find a variety of opinions.

ANATOMIC DIAGNOSIS

1. Malignant lymphoma, histiocytic type, involving the stomach, liver, spleen, pancreas, lymph nodes and bone marrow.
2. Ulceration of gastric lymphoma with massive gastric hemorrhage.
3. Aspiration of blood.

PATHOLOGICAL DISCUSSION

DR. FRANK P. CLEVELAND: The autopsy was performed four hours post mortem on an elderly, well developed and well nourished white female. There were a few patchy pleural adhesions in both cavities and 75 cc. of clear fluid on the right. The heart was essentially unremarkable save for an anatomically patent foramen ovale, which presented a slit-like opening 6 mm. in length. The lungs were focally atelectatic and contained aspirated blood in the bronchi. The peritoneum was thin, smooth and glistening and the cavity contained 400 cc. of clear fluid. The enlarged liver weighed 2440 grams and on its cut surface presented diffusely distributed foci of tumor infiltrate. The gallbladder was moderately thick-walled and contained five facetted black calculi. The spleen weighed 500 grams and on its cut surface also presented small nodular areas of neoplasm.

The cervical, axillary, inguinal, mediastinal and abdominal lymph nodes were enlarged and on section revealed obliteration of the normal nodal architecture. They varied in consistency from firm to semiliquid. Along the greater curvature of the fundus of the stomach there was a thickened mass 6 cm. in diameter. The serosal surface over this thickened area was intimately adherent to the tail of the pancreas and hilum of the spleen.

Within the stomach at this point was an ulcer 2 cm. in diameter which was present at the base of a small outpouching in the fundus, and it was felt that this pseudo-diverticulum had been produced by the adhesions to the tail of the pancreas and hilum of the spleen. At the base of the ulcer there were three hemorrhagic areas which varied from 1 to 2 mm. in diameter and were covered by small plugs of clotted blood. The gastric mucosa was otherwise intact.

The stomach contained 250 cc. of partially clotted blood, and the remainder of the enteric tract contained partially clotted blood throughout its extent. The tubes, ovaries and appendix were surgically absent. The uterus was infantile in its appearance.

Microscopic examination of the original lymph node biopsy specimen from the cervical region revealed destruction of the normal nodal architecture and extensive infiltration by histiocytes which for the most part were mature in appearance. They showed less abundant cytoplasm, pleomorphic nuclei and evidences of degeneration. The microscopic study of the liver revealed diffuse infiltration of the liver by tumor cells with periportal distribution. A section from the ulcer in the stomach demonstrated an erosion of a large vein in the submucosa. The infiltrating tumor cells in the submucosa and muscularis of the stomach also were of the immature type, more closely resembling the stem cell. The bone marrow showed infiltration by large histiocytes, many of which were phagocytic, some exhibiting degenerative changes and others immaturity.

GENERAL DISCUSSION

DR. BLANKENHORN: Do you think there is any connection between the final illness and the enlarged node which appeared in relation to the infected tooth?

DR. CLEVELAND: No, I believe there was no connection between the two. It is not uncommon to have lymphoma supervene in an individual who has had chronic infection of one sort or another.

DR. BLANKENHORN: Doesn't one see lymphoma occasionally with a clinical picture simulating an acute infection with chills, fever and hyperleukocytosis?

DR. CLEVELAND: Yes, indeed, that may occur.

DR. BLANKENHORN: I have seen a patient with such a picture whose enlarged lymph node showed the histologic picture of inflammation but who later had unquestionable lymphoma.

DR. GALL: One may have lymphoma without universal involvement of all nodes. The phenomenon of fever in this disease is a very common one. It is good practice when confronted with a fever of unknown origin to seriously consider the possibility of malignant lymphoma, particularly the Hodgkin's type of the disease. I recall a patient who entered the hospital four or five times in a period of several months with hyperpyrexia attributed to pyelitis. Each time the fever subsided with symptomatic therapy but promptly recurred. At the final admission someone placed all of the fever charts

together and was then able to demonstrate a characteristic intermittent curve of the Pel-Ebstein type. The patient proved to have Hodgkin's disease.

DR. VILTER: In Hodgkin's disease may not the tendency toward necrosis of the lesion contribute toward the development of fever?

DR. CLEVELAND: Of course.

DR. FELSON: In retrospect, would you call the biopsy tissue neoplasm or inflammation?

DR. CLEVELAND: We first were unable to decide whether the lesion was a peculiar reactive process or a malignant neoplasm. I think there is no question that it was the latter in view of the necropsy findings. It is interesting, however, that there is only the barest resemblance between the biopsy and postmortem lesions. Incidentally, we use the terms clasmatocyte and histiocyte interchangeably; the latter name is receiving wider usage and acceptance.

A STUDENT: Was there a terminal leukemia?

DR. CLEVELAND: I think so. The bone marrow showed wide lymphomatous involvement.

REFERENCE

1. Gall, E. A., and Mallory, T. B.: Malignant Lymphoma, a Clinical and Pathological Survey of 618 Cases. Am. J. Path., 18:381, 1942.

Wider Dissemination of Castor Bean Allergen

Allergic disease caused by sensitivity to castor beans, previously reported as a burgeoning problem in Southern California owing to increased use of the pomace as fertilizer, appears likely to affect more and more persons now that the growing, transportation and processing of the beans is becoming more widespread and the chances for exposure to the allergen concomitantly extended.

Considerable increases in production and processing of castor beans in this country in recent years have been induced by a policy of the U. S. Department of Agriculture. During the war years when the hazards of shipping made supply from abroad precarious, the department began a program to encourage production in this country by guaranteeing an attractive price for domestically grown beans and by other means. Now the need for castor oil in jet propelled planes has created additional demand.

In addition, more pomace will be available for fertilizer, and persons who spread it and those who live near where it is used, in urban as well as rural areas, will be exposed to the allergen. A further probability is that since trucks, boxcars, ships and warehouses that have contained castor beans are difficult to decontaminate, other commodities subsequently transported or stored in such facilities also will carry some of the allergen.—Willard S. Small, M. D., Pasadena; *California Medicine*, 78:117, February, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Tobacco—This word is said to come from the West Indian Carib tongue and originally the term "tobacco" was the Indian name for the pipe or tube in which the natives smoked the plant. The term was transferred by the Spaniards from the pipe or tube to the plant itself. However, it is said by some that the name tobacco was given to this plant by the Spaniards because it was a product of the Island of Tabago.

Balmy—The term "he's balmy" or "he's barmy" meaning mentally deranged is a corruption of the expression "He is fit for Barming Asylum." Barming Asylum was a well known 19th Century Insane Asylum in Kent, England.

Tissue—The word tissue was introduced into medical terminology by Marie Francois Xavier Bichat, a French physiologist in about 1800. Tissue was an old term which was applied to a particular kind of rich delicately woven fabric. The word is derived from the French word "tissu" or woven, which in turn comes from the Latin word "texere" meaning to weave. As Bichat studied the structure of the body he likened it to a woven fabric and he described 21 kinds of tissue.

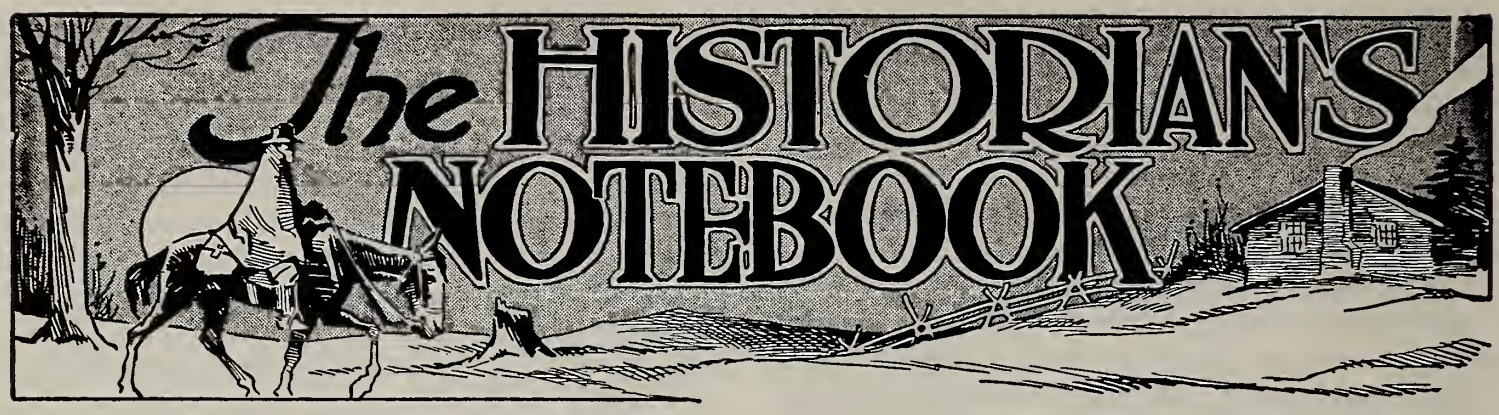
Finger—A finger is literally a grasper and this word comes from the middle English word "feng" or prey. This in turn comes from the Anglo-Saxon word "fangen" meaning to seize.

Spa—This is the name of a town in the province of Liege, Belgium, which has long been famous for its mineral springs, the waters of which are chalybeate, sulphureous and acidulated. Peter the Great of Russia built the pump-room over its principal spring in 1717. Since that time Spa became one of the most popular and frequented of watering places, and the name became adopted as a name for mineral springs everywhere.

Theory—A term which literally means a viewing or a looking at, and which is derived from the Greek words "theoria" a viewing or a sight and "theoros," a spectator. It is a term of ancient usage and was revived along with the medieval translations of Aristotle. The term designates the viewing or contemplation of the abstract principles of a science or art. It is a doctrine covering all the known facts, but for which absolute proof is lacking.

Timothy Grass—This common and widespread "hay fever grass" is said to have received its name in honor of Timothy Hanson, who is said to have carried and introduced this grass seed from New York to Carolina in about 1720.

—HARRY WAIN, M. D., Mansfield, Ohio.



The Development in Pathology in Central Ohio And in Its Medical Colleges (1850-1860)

JONATHAN FORMAN, M. D.

At the meeting of our Society last year, I began a series of communications upon the concepts that physicians of Central Ohio have had concerning disease from the days of the settlement of Columbus. In that first essay, I treated of the years 1800 to 1850. In this essay, I shall discuss the schools of the decade prior to the Civil War (1850-1860). Later I shall retrace my steps to investigate the teaching of pathology in our local medical schools.

In the decade to which I am directing your attention, there were four regular medical schools in Ohio and the Homeopathic School in Cincinnati, as well as those of the eclectic school and the physiomedics. There were already four regular medical journals and three or four "irregular" ones.

In his presidential address delivered before the Ohio Medical Society held in Sandusky on June 2, 1857, the father of the distinguished Dudley Allen and himself a great leader of Ohio medicine, Dr. Peter Allen, brings us to that date with the following:

"The Humoral Pathology, was the doctrine of the schools and of the books, until near the close of the last century. At the commencement of the present century a complete revolution had taken place and almost every vestige of the Humoral Pathology was done away. The discoveries of the microscope, which seem nearly to have arrived at the Cell Theory of the present day, were neglected, and the importance of the fluids except for nutrition, were considered secondary to the solids.

STATE OF THE BLOOD

"It was with these ideas that the medical student, fifty years since, commenced his career in the science of medicine—the old doctrines of a state of the blood existed traditionally among his employers and he would frequently be perplexed with enquiries about the state of the blood. But although the Humoral Pathology was thus laid aside and almost forgotten, it has since been resuscitated and fills an important place in the science of medicine. Like the once conflicting doctrines of Werna and Hutton in the science of Geology, the influence of both solids and fluids are necessary to explain the phenomena of Physiology and disease."

Of course you recognize in this summary, the impact of the conflict between the Viennese and German schools of pathology upon the mind of an intelligent well read medical leader of the decade with which we are now concerned.

In Vienna, Karl Freiherr von Rokitansky, the outstanding pathologist at the Allgemeines Krankeuhaus (1804-78) made a strong attempt to resuscitate the humoral pathology into its position of ancient splendor by carrying the physiologic idea of the nonspecificity of disease processes to the extreme and tracing all pathologic changes to abnormalities in the chemical constitution of the blood. Brilliant as were Rokitansky's contributions to descriptive pathology, his advancement to the humoral theory of pathology was ill advised. In the meantime, the cellular theory was gaining the ascendency under brilliant studies of Johannes Müller and Rudolf Virchow. Virchow published his complete restudy of the entire field of pathology and an extension of it according to microscopic viewpoint in 1858 (translated into English in 1860).

In connection with the use of the microscope which was introduced in medical education here in Columbus in 1850, Dr. John G. F. Holston, as chairman of the committee of the Ohio State Medical Society for 1856-57 reported from which I quote:

"Though the invention of the microscope dates back three centuries, and though even the com-

Read before the Ohio Society of the History of Medicine, Columbus, Ohio, April 5, 1952.

pound microscope has been known since the last century, yet, on account of its many imperfections, it was more a philosophical toy than anything else. True, it told its votary of a mass of living organisms that he had little dreamed of. It peopled earth, air and water, yea, almost fire, for some of these organisms are found in nearly boiling springs and at the crater's mouth. The *form* of the blood, of hair and some other portions of animal and vegetable organization were discovered by it. But yet the views it gave were so very different from the sight of the unassisted eye, and so very inferior, except in point of size, that the imagination of the observer had as much to do to give shape and color to the things observed as his sight, and, as a means for exact investigations it was pronounced worthless.

"In the beginning, however, of this century, the attention of philosophers, at the same time practical opticians, was again directed to the microscope, the causes of its deficiencies discovered and a remedy so fully applied that the microscope may now be considered one of the most perfect philosophical instruments. The faults are spherical and chromatic abberation with a deficiency of light."

MICROSCOPE IN OHIO

But there were but few physicians in Ohio doing anything with the microscope for a broadside and a personal letter sent out by the committee had brought but one reply on the use of this instrument.

Some years ago, O. E. Baker, the great rural sociologist said that it takes about 50 years to get an idea into the conceptual thinking of a people. A man or a group of men get an idea or discover a principle. They tell it to the world, teachers and parents tell it to their children who, in turn, indoctrinate their children. So here, microscopic pathology was being accepted by the profession to have it become a part of the established system of medical education 50 years later.

Dr. Peter Allen had called attention to the fact that "Physiology, aided by the microscope, has made its advance. The important functions of respiration, digestion and many others, are better understood and the cell theory is of modern date (1857). Thus science is in some degree taught in our common schools."

"We must remember also," warned Julius T. Taylor in his presidential address to the Ohio State Medical Society, delivered in Cincinnati June 6, 1854, "there is at this time going on in our sister States and other parts of the world, a renewed desire for the correct advancement of the Science of Medicine. Energy is being redoubled all around us, the age of Theory is passing away, while the age of Facts is coming in its place and that as we are a Society, representing the third State in our glorious Union upon which scientific eyes will be turned with keenness and great interest, we must be exceedingly careful that our doings will be such as will reflect back a character that shall be elevated and honored."

SANITATION AND HYGIENE

"Here . . . we hear everyone, as with authority of a better wisdom, enjoining the observance of his own rules upon his neighbor! In this as in every human interest, fanaticism is ready to take its part. Hence a furor upon the subject of the shower bath, the daily morning ablution, which we have known by way of gratuitous advice to be more regularly urged then by any other means," Robert Thompson warns the Ohio Society at its 1859 Convention. ". . . and all certain to not only insure health, but to be equally beneficial in the removal of disease. And, why? Because 'I did it, and am well; my wife pursued the plan and she was cured' while probably a hungry 'Shanghai' could pick bare the bones of both 'me' and 'my wife.'

"In the year 1848, a man brought into Columbus a shower bath. Why, it was so convenient, like the Dutchman's alarm clock; you had only to pull the string, and be awakened—also showered. If too cold, this shower by arousing reaction, would warm you. If too warm, then was the time to prove its efficacy—it would cool you; and then it was so nice; everybody should and everybody did have them; and many got more for their money than they contracted for—bad colds, bronchitis, pulmonary engorments, old pain confirmed, wandering pains located, and occasionally, a cleaner surface, if they would wipe dry, soon after showering; all of this train of events followed in the Nature of the case.

"After a while, the demand for 'pure cod liver oil' increased to such an extent as to remind some of the two Yankee peddlers—the first peddling the disease, while the second followed selling the remedy."

Those of us who are always impatient with the great gaps that still remain in our practical knowledge in the fields of hygiene and try strengthening ourselves by what we can learn of Nature's way to fill in more or less empirically these gaps in our program of living, might do well to listen to the warnings of Dr. G. Volsey Dorsey of Piqua in his address before the Ohio State Medical Society in its session of 1854.

"The progress of science is steadily onward; prejudice may object, ignorance may oppose, and empiricism in all its forms, may throw out its delusions to ensnare the unwary, but in spite of all, true Science, powerful in its armor of truthfulness and right, will continue to win its way to the confidence and affections of Man; whose every obstacle which is placed in its way, shall be overthrown by the progressive person,

as the feeble barrier is swept away by the onward current of an ugly river."

TUBERCULOSIS

We can get some idea how concepts of diseases affected the physician's thinking by the report of Dr. L. M. Lawson to the 1854 convention of the Ohio Medical Society. He reported, on tuberculosis, as follows:

"No climate, age or condition is exempt from its insidious ravages; the robust and athletic man, the mere infant—young and old—though not equally liable, are, nevertheless, but too often victims of the disease. Bred in the very composition of the tissues—bone and muscle—membrane and blood—all become contaminated, and finally decay and the inscrutable disease spreads throughout the system.

"There is a period, however, when the disease consists not in a morbid deposit but on what has been and still is called a *diathesis* and this is the period when our remedies may be most successfully employed, before a fatal disorganization takes place. This constitutional predisposition has been erroneously called a functional condition and not an actual disease." . . .

"That this conclusion is something more clearly proven by the analysis of the blood, the examination of the tissues, and the general physical confirmation, long anterior to the deposit of tubercles the blood is found deficient in globules, hematin and iron, with an excess of albumin and water and altered or depraved fibrin."

He concludes with a role of optimism that has always disintegrated the writings of Ohio physicians about the white plague:

"The science of medicine is not impotent, nor is consumption a hopeless malady. The art of man has not been able to remedy hydrophobia, for we know nothing of its nature; but it is not thus in the tubercular constitution, or the tubercular development. The fluids and solids have been carefully examined, and their deviations from health discovered, and he who has a fair comprehension of their changes, and can diagnose their existence at an early period, may be so fortunate as to arrest disease, or prolong life. It is to this source then that we must direct our efforts."

How modern does the rest of this report sound?

"Accuracy in pathology, early and correct diagnosis, and a due appreciation of remedies, and their proper combinations, will often crown with success the efforts of the philosophical practitioner; while he who is seeking specifics is soon lost in the mazes of his own groundless conjunctures and is rewarded with disappointed hope as the first of his ill-directed labors."

PUERPERAL FEVER

The contagious character of this affliction was still somewhat in dispute but Dr. A. Metz insisted before the 1859 Convention of the Ohio State Medical Society here in Columbus that

"Although two of our most able systematic authors in this country are strong advocates for non-contagion, at the present time no fact in medicine appears better established, than is the contagious nature of puerperal fever. It is to be feared that the medical practitioner often neglects to exercise the precautions demanded by the contagious character of this disease."

Dr. Metz then goes on to urge the physician who is taking care of cases of puerperal fever, scarlatina, and erysipelas to turn his obstetrical patients over to some one else no matter how reluctant one may be to pass one's patients into the hands of another.

OVARIAN TUMORS

In 1859, the distinguished surgeon, Dr. John W. Hamilton, founder of the Hawkes Hospital of Mt. Carmel here in Columbus, father of the late Drs. Will and Charles Hamilton and preceptor of Dr. Josiah Medberry, my old professor of Anatomy, gave this report on Ovariotomy in Ohio, to the state Society. To that date the operation had been performed or attempted 42 times, where patient and operation belonged in the State of Ohio. In eight cases by Ohio surgeons upon patients from other states and in one case upon a resident of Ohio by a surgeon in another state, making a total of 51 cases. Of these 25 had not been recorded before. In 21 cases there was recovery, after extirpation, without relapse, and were thereafter attended by uniformly good health!

Here we are interested in the surgeon's concept of the presenting pathology. We have a surgical pathological diagnosis in 41 of the 51 cases. Of these 32 were cystic, 17 compound, 12 simple and two named simply "cysts," six were called fibrosis or solid, two omental, two uterus and one tubal fetation.

Dr. Hamilton drew the practical lesson from this that since in the 11 solid tumors only two were cured by extirpation, "there ought, accordingly, so far as this experience goes, to be no hesitancy in rejecting the extirpation of solid tumors supposed to be ovarian, as an accredited surgical procedure; especially as it is a matter of common observation that they are usually of slow growth and not necessarily incompatible with a comfortable or even protracted existence." But the removal of the other tumors had added 496 years of good health or statistically 15 to 1.

In conclusion, may I say that we are gradually tracing in these papers the conceptual thinking of Ohio physicians about disease from the days of the Northwest Territory to the present time. To-day, I have attempted to sample the writings and speeches of the leaders of Ohio Medicine during the decade just preceeding the war of the Rebellion (1850-1860).

Annual Meeting High Lights . . .

Panorama of Special Events Supplementing Scientific Program of the Ohio State Medical Association Convention, Cincinnati, April 21-23

The House of Delegates, policy making body of the Ohio State Medical Association, will meet twice during the Annual Meeting. The first meeting will be at 4:00 p. m. on Tuesday and the second at 1:00 p. m. on Thursday. Between these two meetings, various committees of the House will ponder matters referred to them and will present their recommendations at the second meeting. Although the dinner and luncheon are reserved for delegates and others attending in an official capacity, any member of the Association is welcome to attend these sessions.

* * *

Eight specialty sections, including the Section on General Practice, are presenting programs for their members. Six General Sessions also are scheduled. Therefore physicians in virtually every branch of practice will find features to their liking. Those attending the meeting, regardless of branch of practice, are welcome to attend any of the specialty section programs.

* * *

Plan to devote as much time as possible to the Scientific and Educational Exhibits at the Netherland Plaza Hotel. Ample recess time has been allotted especially for this purpose. High lights of much of recent research and medical developments will be found here.

* * *

Something new at this meeting will be showing of specially selected medical motion pictures each morning as part of the program. Don't miss these special features. The committee which selected the pictures has assigned a commentator for each.

* * *

A pre-convention meeting will be that especially designed for officials and chairmen of certain county society committees to be held on Monday afternoon, April 20, at the Netherland Plaza Hotel.

Those who receive invitations will be expected to attend a complimentary luncheon at noon. All members in good standing with the profession are invited to attend the program which begins at 1:30 p. m.

* * *

The Woman's Auxiliary to the Ohio State Medical Association is holding its Annual Meeting this year at the Hotel Sheraton-Gibson, for the four days, April 20-23. See detailed program elsewhere in this issue.

Thirteen guest speakers, each a nationally known figure in his field of medicine, have accepted invitations to speak at the Annual Meeting. Consult your program for names of these guests and their topics. Several of them will speak both at specialty section meetings and at general sessions.

* * *

Top social event of the Annual Meeting will be the Annual Banquet on Wednesday evening at the Netherland Plaza Hotel. Because space is limited, reservations for this event should be made as early as possible. An excellent dinner, followed by entertainment and an evening of dancing are in store. Price of each ticket will be $6.50, including dinner, tax, tips and entertainment.

* * *

The Ohio State Heart Association and its affiliates are presenting a program for all members of the profession who wish to attend on Thursday afternoon, April 23, in Hotel Gibson. Refer to the March issue of *The Journal* for features of the program.

* * *

The Annual Meeting of the Ohio Chapter of the American College of Chest Physicians will be held in the Hotel Sheraton-Gibson, Parlor E, on Wednesday, April 22, at noon.

* * *

A number of events are planned in addition to the regular program features, such as class reunions and group get-togethers of various kinds. Among these is the Jefferson Medical College Alumni get-together at the Town and Country, Covington, Ky., on Tuesday.

* * *

The Technical Exhibits are an education in themselves. Carefully screened, they represent only the most ethical supply houses. Here is an opportunity to sit down and discuss with your detail men the latest developments in pharmaceuticals, instruments, diagnostic equipment and other supplies of the profession.

* * *

The Ohio Psychiatric Association will hold its annual meeting beginning on Monday, April 20 at 2:00 p. m. with the last feature of the program beginning at 3:00 p. m. on Tuesday.

* * *

The Cincinnati Obstetrical Society is sponsoring for the obstetricians and gynecologists of the

Ohio State Medical Association, a get-together for cocktails, dinner and entertainment on Tuesday, April 21, at 6:00 p.m. in Parlors A-D, Netherland Plaza Hotel. Those who plan to attend are requested to send reservation and check in the amount of $8.00 to Dr. Stanley T. Garber, 104 William Howard Taft Rd., Cincinnati 19.

* * *

The Cincinnati Art Museum has extended an invitation to all persons attending the Annual Meeting to visit its first-rank collections. Rated among the top ten in the United States, this museum is notable for its new collections of Far and Near Eastern art, 18th and 19th century "period rooms," ancient musical instruments, sculpture hall and comprehensive painting and print collections. The museum is open Tuesday from 1:00 to 10:00 p.m., daily from 10:00 a.m. to 5:00 p.m.; Sundays from 2:00 to 5:00 p.m., It is located in Eden Park. From downtown, it may be reached by taking the Zoo-Eden Bus 49 or motoring via Gilbert Avenue. Admission is free.

Resolutions To Be Presented . . .

County Medical Societies Announce Texts of Resolutions Which Their Delegates Will Put in Hopper for Consideration by House of Delegates

FOLLOWING are texts of three resolutions which will be presented by delegates of the county medical societies for consideration by the House of Delegates of the Ohio State Medical Association during the Annual Meeting in Cincinnati, April 21-23. They are being published in advance in *The Journal* in compliance with the recommendations of the By-Laws of the Association.

Resolution from the Academy of Medicine of Cincinnati:

Whereas, it is assumed that every elected delegate to the Ohio State Medical Association Annual Meeting desires to do a conscientious job with full integrity; and

Whereas, only a few of the resolutions to be introduced in the House of Delegates are submitted for perusal in advance, leaving many resolutions to be verbally stated at the first of the two meetings of the House, without full opportunity for most of the delegates to study the content of these resolutions and to digest it thoroughly; and

Whereas, this situation could be rectified by putting printed copies of all resolutions into the hands of all delegates between the two meetings of the House of Delegates, now, therefore

Be It Resolved: That a copy of every resolution submitted to the House of Delegates at the Annual Meeting of the Ohio State Medical Association be presented in printed (mimeographed) form to every delegate before action is taken upon the resolution.

Resolution from the Academy of Medicine of Cincinnati:

Whereas, the county medical societies of the State of Ohio are collecting American Medical Association dues, which are, in turn, certified to the Ohio State Medical Association for recertification to the American Medical Association; and

Whereas, the procedure of dues collection for the American Medical Association involves considerable additional expense for county medical societies, thereby creating an extra financial burden and the expenditure of funds collected from members of local county medical societies, some of whom are not members of the American Medical Association; and

Whereas, the officers of the local county medical societies are compelled to use the funds collected as dues from all members of their society for expenditures incurred in behalf of the American Medical Association, now, therefore

Be It Resolved: That the Ohio State Medical Association request an adequate allowance of funds from the American Medical Association in order that local county medical societies may be reimbursed for the expenditures incurred in the collection of dues for the American Medical Association.

Resolution from the Jefferson County Medical Society:

Be It Resolved: That assignments or payments from the Ohio Medical Indemnity, Inc., be made to the subscribers' physicians or to the subscriber and his physician as co-assignees.

American Congress of Physical Medicine and Rehabilitation

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 31 - September 4, at the Palmer House, Chicago.

Full information may be obtained by writing American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2.

Scientific and Educational Exhibit . . .

Will Be One of the Main Attractions of the Association's Annual Meeting, April 21-23, in Cincinnati; 40 Displays Are Scheduled

ONE of the main attractions at the 1953 Annual Meeting of the Association in Cincinnati, April 21-23, will be the Scientific and Educational Exhibit, which will be in the South Hall, Fourth Floor of the Netherland Plaza Hotel. It will be open from 9:00 a. m. to 6:00 p. m. on Tuesday and Wednesday and from 9:00 a. m. to 3:00 p. m. on Thursday. Ample time has been allotted throughout the program to allow physicians to study these exhibits carefully. The following list indicates the title of the exhibit and the sponsor or sponsors:

Booth No.

OFFICE, COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBITS S-1
John F. Mueller, M. D., Chairman.

EXPERIENCES WITH ACTH AND CORTISONE IN HEMATOLOGY S-2
Richard W. Vilter, M. D., John F. Mueller, M. D., Thomas Jarrold, M. D., Virginia R. Hawkins, R. N., Carl G. Thompson, M. D., John J. Will, M. D., Hematology Laboratory, Department of Medicine, University of Cincinnati.

REVASCULARIZATION OPERATIONS FOR CORONARY ARTERY DISEASE S-3
Claude S. Beck, M. D., David S. Leighninger, M. D., Cleveland.

RARE MUCOUS MEMBRANE LESIONS S-4
Ashton L. Welsh, M. D., Mitchell Ede, M. D., Richard M. Oliver, M. D., Cincinnati.

STROKES S-5
Keith W. Sheldon, M. D., Cleveland.

HISTOPLASMOSIS IN MAN AND ANIMALS S-6
John A. Prior, M. D., Samuel Saslaw, M. D., Clarence R. Cole, D. V. M., Deane Chamberlain, D. V. M., Department of Medicine and Veterinary Pathology, Ohio State University.

TREATMENT OF PEPTIC ULCER WITH UNLIMITED DIET S-7
E. A. Marshall, M. D., Huron Road Hospital, Cleveland.

CARCINOMA OF LUNG S-8
Karl P. Klassen, M. D., The Health Center, Ohio State University.

VIBRATORY LEVELS IN DERMATOLOGY S-9
Samuel Goldblatt, M. D., Cincinnati.

HELP IMMUNIZE ME AGAINST ACCIDENTS S-10
American Academy of Pediatrics, Cincinnati Pediatric Society, Ohio Department of Health.

HIATAL HERNIAS S-11
Saul A. Rosenblum, M. D., Dayton.

EXPERIENCE WITH RADIOISOTOPES S-12
Archie Fine, M. D., Lee S. Rosenberg, M. D., S. Taplits, M. D., Jewish Hospital, Cincinnati.

Booth No.

HYPOGONADISM, CRYPTORCHIDISM AND INFERTILITY IN THE MALE S-13
Arthur A. Roth, M. D., Cleveland.

GASTROJEJUNOSTOMY S-14
I. Henry Einsel, M. D., The Woman's Hospital, Cleveland.

PLASTIC AND RECONSTRUCTION SURGERY S-15
J. J. Longacre, M. D., Cincinnati.

THE INTRAVENOUS ADMINISTRATION OF STEROID HORMONES S-16
Irving Rothchild, M. D., Department of Obstetrics and Gynecology, Ohio State University.

CLASSIFICATION AND CLINICAL MANAGEMENT OF MENTAL DEFICIENCY S-17
Roger M. Gove, M. D., Columbus State School.

MODERN CONCEPTS OF THE INGUINAL CANAL: THEIR RELATIONSHIP TO INGUINAL LIGAMENT AND COOPER'S LIGAMENT AND HERNIA REPAIR S-18
C. C. Burton, M. D., Veteran's Administration Hospital, Dayton, Department of Surgery, University of Cincinnati.

INTRALARYNGEAL APPROACH AND ARYTENOIDECTOMY IN BILATERAL ABDUCTOR VOCAL CORD PARALYSIS S-19
William C. Thornell, M. D., Department of Otolaryngology, University of Cincinnati.

OHIO STATE HEART ASSOCIATION SERVING OHIO THROUGH RESEARCH EDUCATION COMMUNITY SERVICES S-20
Ohio State Heart Association, Columbus.

CONTRACEPTIVE PRACTICES OF THE CLINICAL TYPE PATIENT S-21
Allan C. Barnes, M. D., Planned Parenthood League of Ohio, Columbus.

CARCINOMA OF THE STOMACH CHANGES IN SURGERY 1940-1952 ..... S-22
Charles H. Brown, M. D., S. O. Hoerr, M. D., R. G. Perryman, M. D., Cleveland Clinic.

VOIDING URETHROGRAPHY IN CHILDREN S-23
Frederic N. Silverman, M. D., Children's Hospital, Cincinnati.

EASTER SEAL SERVICES S-24
The Ohio Society for Crippled Children, Columbus.

CONTACT ROENTGEN THERAPY OF SUPERFICIAL LESIONS S-25
Arnold D. Piatt, M. D., Gerald A. Erhard, M. D., Newark.

USE OF LONG ACTING CURARE IN ANO-RECTAL SURGERY S-26
Norris E. Lenahan, M. D., St. Anthony Hospital, Columbus.

Booth No.

CANCER OF COLON AND RECTUM S-27
Ohio Division, American Cancer Society, Inc., Cleveland.

SERVICES TO PHYSICIANS FROM OHIO DEPARTMENT OF HEALTH S-28
Ohio Department of Health, Columbus.

IMPROVED TECHNIQUE OF CYCLODIALYSIS S-29
K. W. Ascher, M. D., Departments of Ophthalmology and Medical Arts, University of Cincinnati.

ACUTE DIFFUSE PNEUMONIA OF ASTHMATICS S-30
Benjamin Felson, M. D., Henry Felson, M. D., Departments of Radiology and Medicine, University of Cincinnati.

COARCTATION OF THE AORTA S-31
Charles V. Meckstroth, M. D., Karl P. Klassen, M. D., Thoracic Surgery Service, The Health Center, Ohio State University.

TESTS OF RESPIRATORY FUNCTION S-32
Constance J. Connors, M. D., R. H. Browning, M. D., Ohio Tuberculosis Hospital, Columbus.

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Auxiliary Annual Meeting . . .

Thirteenth Program for Doctors' Wives Will Be Held Concurrently With the Association's Three-Day Annual Meeting in Cincinnati

THE Thirteenth Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held at the Hotel Sheraton-Gibson, Cincinnati, Monday to Thursday, April 20 to 23. Wives of physicians who attend the Association meeting are invited to attend the sessions of the Auxiliary.

PROGRAM

MONDAY, APRIL 20

1:00 P. M. Resolutions Committee Meeting
Hotel Sheraton-Gibson

3:00 P. M. Pre-Convention Board Meeting
Hotel Sheraton-Gibson

6:30 P. M. Dinner for Board Members
Hotel Sheraton-Gibson

TUESDAY, APRIL 21

9:00 A. M. Registration

9:30 A. M. Opening Session
Presiding: Mrs. Paul Woodward, President
Pledge of Allegiance to Flag
Invocation: The Reverend Dr. John H. Lamy
Pledge of Loyalty: Mrs. E. Benjamin Gillette
Address of Welcome: Dr. Daniel Earley, President, Academy of Medicine of Cincinnati
Greetings: Mrs. William Lippert, President, Woman's Auxiliary to Academy of Medicine of Cincinnati
Response: Mrs. H. M. Clodfelter
Introduction of Convention Chairmen
Report of Roll Call Chairman: Mrs. J. Nielander
Adoption of Rules of Convention
Minutes of 12th Annual Meeting: Mrs. O. Reed Jones
Treasurer's Report: Mrs. C. E. Cassaday
Report of Nominating Committee: (first reading), Mrs. W. R. Gibson
President's Address: Mrs. Paul Woodward
Reading of Necrology: Mrs. A. Paul Hancuff
Report of Resolutions Committee: (first reading), Mrs. Homer I. Keck
Credits and Awards: Mrs. E. W. Cauffield
Election of Delegates to National Auxiliary Convention
Recess

12:00 Noon Luncheon: Honoring . . . Past Presidents of the Woman's Auxiliary to the Ohio State Medical Association; Mrs. J. L. Stevens and Mrs. Harold K. Mouser, Honorary Members; State Board Members

1:00 P. M. Speaker: Mr. Thomas A. Hendricks, Chicago, Secretary of the A. M. A. Council on Medical Service, "Homework Comes First"

1:30 P. M. Skit—Fashion Show: Members of the Hamilton County Woman's Auxiliary and the H. and S. Pogue Company Arranged by Mrs. Harry K. Hines and Mrs. H. L. Fry

2:30 P. M. Convention Conferences

2:30 - 3:00 P. M. Nurse Recruitment: Moderator: Mrs. Frank Stevenson

3:00 - 3:30 P. M. Public Relations: Moderator: Mrs. Ross Knoble

3:30 - 4:30 P. M. School of Instruction for County Presidents and Presidents-Elect: Mrs. N. M. Reiff

3:30 - 4:30 P. M. School of Instruction for District Directors: Mrs. A. Paul Hancuff

Tuesday Evening: There will be a card party in the Hospitality room. Tables for canasta, bridge or your favorite game will be available. There will be a prize for each table. This will be an informal meeting place for all Auxiliary members.

WEDNESDAY, APRIL 22

9:00 A. M. Second Session
Presiding: Mrs. Paul Woodward
Report of Roll Call chairman
Report of Resolutions Committee (second reading)
Minutes of previous meeting
Unfinished business
New Business
Report of Finance Chairman: Mrs. Farrell T. Gallagher
"Thirteen Years of Auxiliary in Ohio"—Mrs. G. W. Kirkland
"History of Our National Auxiliary"—Mrs. W. O. Mermis

10:00 A. M. Conferences
Program: Moderator: Mrs. James E. Mullen
Publications: Moderator: Mrs. V. R. Frederick
A. M. E. F.: Moderator: Mrs. G. W. Cooperrider
Civil Defense: Moderator: Mrs. Craig Wales
Civil Defense Talk: Mrs. Norton H. Pearl, Assistant Director for Woman's Affairs in Civil Defense

1:00 P. M. Luncheon: Choral Grace: Hamilton County Choral Group
Words and Music: Margaret McClure Stitt
Honoring: Mrs. Ralph Eusden, President, Woman's Auxiliary to the American Medical Association; Dr. E. J. McCormick, Toledo, President-Elect of the A. M. A.; Dr. H. M. Clodfelter, Columbus, Presdient of the Ohio State Medical Association; Dr. and Mrs. N. M. Reiff; Dr. and Mrs. Paul Woodward and County Presidents
Choral Group—Woman's Auxiliary to the Hamilton County Medical Society Choral Group Arranged by Mrs. John Marioni, Directed by Mrs. Charles Sherrick; Accompanist: Mrs. Daniel Jones

2:00 P. M. Third Business Session
Report of Roll Call Chairman
Report of Convention Chairman
Report of Nominating Committee (second reading)
Unfinished business
New business
Election of Officers
Address and Installation of Officers: Mrs. Ralph Eusden
President's Address: Mrs. N. M. Reiff

7:30 P. M. Annual Banquet, Ohio State Medical Association
For those not attending the banquet, there will be a card party in the Convention Hospitality Room.

All Auxiliary members are urged to attend all the meetings whether they are delegates or not. The panels and conferences will be interesting and educational to everyone interested in the Medical Auxiliary.

THURSDAY, APRIL 23

10:00 A. M. Brunch
Post-Convention Board Meeting—Mrs. N. M. Reiff, Presiding.

Emergency 'Phone Service Will Be Provided at Annual Meeting

Physicians who plan to attend the Annual Meeting of the Association in Cincinnati, April 21-23, may wish to leave with their office secretaries information as to how they may be reached in cases of emergency. With the assistance of the Academy of Medicine of Cincinnati, a special desk will be maintained in the Netherland Plaza Hotel for the purpose of relaying emergency telephone calls to physicians attending the meeting. A straight line will connect the information desk with the Cincinnati Academy office. A main line also will be installed for the meeting and the number will be DUnbar 4960. (This is the number physicians may wish to leave with their secretaries.) Physicians who are expecting emergency calls should leave their names and information as to where they expect to be at the information desk. The desk will be maintained only during program hours. Evening and night calls will have to come through the physician's hotel.

Diphtheria . . .

Health Director Surveys Situation in Ohio; Recommends Alertness To Danger and More Vigilant Immunization Program Among Children

DIPHTHERIA has raised its head again in Ohio and has taken its toll—an indication that the disease is lurking undetected in many areas of the State. In fact, health officials, after an outbreak in one area, discovered 55 children in one school who were carrying diphtheria organisms.

Dr. John D. Porterfield, director of the Ohio Department of Health, has issued a statement which emphasizes the seriousness of the situation. He urges that all physicians use the utmost care in diagnosing cases in which diphtheria may be suspected; also that county medical societies and individual physicians use their utmost effort in promoting immunization programs in their communities.

The statement follows:

DR. PORTERFIELD'S STATEMENT

The basic need for intensive and comprehensive immunization programs in the health jurisdictions of Ohio has been emphasized by communications from this department on several occasions. Recent deaths from diphtheria which have occurred in several of Ohio's counties and the discovery of large numbers of school children carrying virulent diphtheria organisms make it necessary to stress again the absolute necessity of these programs for the protection of the public health.

It is almost universal practice now among physicians to treat sore throat with penicillin without making an attempt to arrive at the proper diagnosis by the use of the throat swab. This results in missed cases, unsuspected carriers, and death certificates signed "acute laryngotracheobronchitis" or, if the child survives the acute disease, "myocarditis."

The recent experiences of the Division of Communicable Diseases, Ohio Department of Health, has shown that scrutinizations and follow-up of death certificates of this type frequently lead to previously unrecognized diphtheria.

DEGREE OF IMMUNITY

In most communities a reasonable percentage of children of school age have some degree of immunity. Diphtheria being introduced into the school, therefore, may be manifested by an outbreak of upper respiratory morbidity which is passed off as "strep throat," "flu," "pharyngitis," or "hard cold" without the proper diagnosis of diphtheria having been suspected.

In the pre-school population, however, the amount of immunity is much less and clinical diphtheria is much more frequent. This is well demonstrated by a recent investigation of a school in one county where over a period of two months an outbreak of sore throat had been occurring. When the entire school population was cultured it was discovered that fifty-five of the children and two of the teachers were carrying virulent diphtheria organisms. No cases of diphtheria had been reported in this school. During the same period, however, three diphtheria deaths in non-immunized pre-school children and one severe case of diphtheria in an adult occurred.

IMMUNIZATION PROGRAM

Death and morbidity from diphtheria are evidences of failure on the part of physicians and of the responsible public health authorities to carry out time-proven immunization procedures. It is obvious that intensification of both school and pre-school immunization programs is absolutely essential. If high school students and adults are to be protected, attention must also be given to booster shot programs. It should never be forgotten that the immunity engendered by diphtheria toxiod is of limited duration and must be enhanced by repeat injections at three to five year intervals.

It is suggested that this topic is one which should be talked over with your local medical society. The physician's role in stimulating immunization procedures in his practice, in having a high degree of suspicion in cases of "sore throat," in utilizing available laboratory resources and in reporting diagnosed cases is a key one. Your medical society's cooperation in bringing this to physicians' attention should be most helpful.

Movies Available for Use On Television

The Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, announced that it has made available three movie shorts for use on television. They are offered to state and county medical societies as a public service.

One movie is entitled "Once Upon a Time." It is a 10-minute, animated cartoon dealing with safety on the highways. Another 10-minute sound film, "Proof of the Pudding," is a dramatic presentation of the essentials of good nutrition. The third, "Be Your Age," is the story about a middle-aged, overweight man who has recovered from a heart attack.

Health Department Budget . . .

Unless Legislature Boosts Amount Recommended by Governor, Ohio Will Again Have to Look to Washington for Substantial Help

UNLESS the Ohio General Assembly now in session makes substantial increases in the budget recommendations of the Governor for the Ohio Department of Health's 1953-1954 biennium, that department again will have to look to the Federal Government for a considerable portion of its operating funds.

The department has estimated that it will need $4,111,764 for the biennium in order to maintain the present level of personnel and volume of activities as called for by state statute and local demand.

The Governor's budget recommends an appropriation of $2,096,758 from state funds for the health department.

Therefore, to meet its operating expenses, the department will be forced to use $2,015,006 from Federal grants to finance departmental activities.

During the biennium the department expects to receive a total of $2,903,283 in Federal grants in aid. This is only an estimate and may be reduced if Congress follows through with its intention to cut the Federal budget.

Since $2,015,006 of the estimated Federal grants will have to be used by the department for central office operating costs, only $888,277 in Federal money will be available for aid to local health departments and field training programs in public health. Warnings have been issued by the Federal Government that grants-in-aid should be used mostly for aid to local health departments. However, Ohio continually has had to cut deeply into the Federal grants to support the State Department of Health.

SPECIFIED SUBSIDIES NOT MET

The Governor's budget recommends only $320,000 per year for the biennium as state subsidies to local health departments, despite the fact that this annual amount should be $410,000 under existing state law.

Organizations and groups interested in correcting this bad plan of financing the Ohio Department of Health are being urged to contact members of the State Legislature; point out the problem; urge legislators to vote for increases in the Governor's recommendations.

The Ohio Rural Health Council, which has been a pioneer in efforts to secure more state money for the department, has published a pamphlet airing the facts and making certain recommendations for action. It reads in part as follows:

"The Ohio Department of Health is doing a good job. But dependence on Federal handouts has placed the department at the mercy of the whims and fancies of budget makers in Washington.

"The department is subjected, in theory, to the dictation of Federal administrators who place restrictions and regulations on the use of Federal funds. This is not good financing. It is not good government.

"Federal funds are being withdrawn. The State must support the health department's statutory activities or fail completely to provide essential health protection required by law.

"Unless the legislature rescues its health department vital medical civil defense activities also will suffer."

The pamphlet concludes with a paragraph urging its readers to see their state representatives and senators while they are at home on weekends. It urges letters and phone calls but points out that personal calls are even better.

Entitled "Ohio Can Have Better Public Health" the booklet is available from Mr. Guy Dowdy, secretary, Ohio Rural Health Council, Townshend Hall, Ohio State University, Columbus, Ohio.

Cincinnati Area General Practitioners Hold Series of Seminars

Following are some of the subjects and speakers featured in recent weekly seminars by the Southwestern Ohio Society of General Physicians, in collaboration with the University of Cincinnati College of Medicine:

February 19—Dr. Vinton E. Siler, assistant professor of surgery, "Management of Common Injuries of the Hand"; Dr. Bruce G. MacMillan, instructor in surgery, "Management of Carbuncles and Furuncles."

February 26—Dr. Jerome J. Giuseffi, instructor in surgery, "Treatment of Infections Encountered in Minor Surgery"; Dr. William A. Altemeier, professor of surgery, "Chemotherapy."

March 5—Dr. Joseph P. Evans, associate professor of surgery, "Diagnosis and Emergency Management of Head Injuries"; Dr. James J. Cranley, Lucie-Rawson fellow in vascular surgery, "Varicose Veins of the Lower Extremity and the Differential Diagnosis and Management of Leg Ulcers."

March 12—Dr. Paul I. Hoxworth, assistant professor of surgery, and Dr. Stewart R. Jones, assistant clinical professor of surgery, "Diagnosis and Management of the Common Anorectal Lesions"; Dr. Jean M. Stevenson, assistant professor of surgery, "Dressing and Bandaging of Wounds (Demonstration)."

Rural Medical Facilities Increasing . . .

Medical and Other Groups Are Teaming-Up for Real Results, National Conference Reveals; Ohio Well Represented at Roanoke, Va., Meeting

MEDICAL care facilities in rural areas are increasing rapidly through cooperative, voluntary efforts of medical, farm, and community groups, it was reported during the eighth National Conference on Rural Health, held at Roanoke during February.

The meeting was attended by about 600 representatives of medical and agricultural organizations, university extension services, health departments and others. Forty-two states and the District of Columbia were represented at the meeting, which was sponsored by the Council on Rural Health of the American Medical Association.

DR. MUNDY SPEAKS

Dr. Carll S. Mundy, Toledo, Fourth District Councilor of the Ohio State Medical Association and vice-chairman of the sponsoring council, discussed problems associated with bringing voluntary prepayment medical care insurance to farmers and their families as an economical means for them to meet their medical care costs.

"Since payroll deduction is impossible for farm families some other satisfactory and economical arrangement must be made to collect and forward premiums for this group," Dr. Mundy said.

In citing some examples, he said that successful groups have been formed within farm organizations, among church members and among depositors of rural banks.

Dr. Mundy stated that a group must be not only qualitatively representative, but quantitatively it should include more than fifty per cent of the farm families in a community.

He pointed out that the farmer would have a more economical and better coverage for his purpose if he took advantage of the deductible principle which eliminates the insurance of small, frequently recurring and unpredictable items. "The greater the number of small items we permit to remain in this deductible category, the cheaper will be the insurance," Dr. Mundy said.

The hospital bill probably will be the largest item in the cost of a major illness, he told the conference, and surgical fees are usually the second largest item, in those cases where surgery is performed.

CLINTON COUNTY PROJECT CITED

Clinton County, Ohio, as a result of conditions found in its health survey conducted two years ago, embarked upon a program to provide better medical care and to develop additional preventive measures reported Dr. Edmond K. Yantes, Wilmington, member of the Rural Health Committee of the Ohio State Medical Association, and Secretary to the Clinton County Health Council.

Some of the signs of progress enumerated by Dr. Yantes are:

1. New doctors have been attracted by the building of a general hospital.
2. Infant mortality has been decreased.
3. Unsanitary conditions have been reduced.
4. Immunization of children against smallpox and diphtheria has reached about 90 per cent.
5. Milk pasteurization has been instituted.
6. Children entering school are being given check-ups, and plans are under way for expansion of the school health program.

HOW TO GET A DOCTOR

Dr. B. N. Saltzman told the meeting he chose to practice in Mountain Home, Arkansas, an Ozark mountain town of about 2,000 in preference to specializing in one branch of medicine after his release from the Army Medical Corps seven years ago.

His suggestions to a community which is in need of a doctor were: That it let the doctor be invited by organized action of community leaders willing to back up their promises; that it not needlessly work the doctor to death; that it provide a small community-owned hospital, open to all reputable physicians in the area.

Among those attending the meeting from Ohio, in addition to Drs. Mundy and Yantes were: Dr. J. Martin Byers, Greenfield, chairman of the O. S. M. A. Committee on Rural Health; Dr. H. T. Pease, Wadsworth; Dr. E. G. Caskey, Mineral Ridge; and Dr. V. R. Fredericks, Urbana, all members of the committee; and Mr. Hart. F. Page, of the Association's Columbus office, its secretary.

The 1954 conference will be held in Dallas, Texas, March 4-6.

COLUMBUS MEETING

A Rural Health Leadership Training Institute was held in connection with the Ninth Annual Meeting of the Ohio Rural Health Council in Columbus, March 10 and 11,

A definite departure from the usual program of the Council's annual meeting, the institute was devoted to the discussion of techniques of program planning, finding resources, and determining goals for district rural health meetings.

For the purposes of the program of the Coun-

cil, the state is divided into 22 areas of approximately four counties each. Each area has an elected representative to the Council.

Each year a one-day district health conference is held by three areas, in most cases 12 counties, whose leaders work together to plan a program around the health problems and needs of the district. This year's annual meeting was devoted to increasing the efficiency of these meetings.

On the staff of the institute from the Ohio State Medical Association were Dr. Edmond K. Yantes, Wilmington, a member of the Committee on Rural Health and its representative to the Ohio Rural Health Council, and Mr. Hart F. Page, secretary to the O. S. M. A. Committee and a member of the Council's program committee.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsements of their licenses to practice in other states (intended residence and medical school of graduation also is given):

December 2: George L. Altman, Youngstown, University of Illinois; Joseph L. Bitzan, Cleveland, St. Louis University; David H. Black, Toledo, McGill University; Joseph R. Boyle, Cleveland, Syracuse University; Joseph P. Brady, Gallipolis, Long Island College;

Mary Helen Cameron, Bryan, University of Colorado; Andrew R. W. Climie, Toledo, University of Glasgow; Robert E. DeLashmutt, Bucyrus, George Washington University; Herbert Fleischl, Dayton, University of Vienna; James G. Gianakopoulos, Springfield, New York State University; John P. Goff, Findlay, University of Pittsburgh; Evelyn F. Golomb, Cleveland, Woman's Medical College of Pennsylvania; Louis E. Harman, Jr., Cincinnati, Duke University;

Loren E. Hart, Jr., Dover, Northwestern University; Robert C. Hawkins, II, Toledo, University of Nebraska; Robert A. Kemper, Cincinnati, University of Louisville; Donald H. MacPherson, Marion, Tufts College; Alexander C. Minella, Cincinnati, Georgetown University; Lucille M. Munion, Cincinnati, Long Island College;

Gerhard S. Nothmann, Cleveland, University of Bern; John L. Paulus, Lakewood, Columbia University; Cary S. Peabody, Youngstown, University of Michigan; George B. Pugh, Youngstown, Cornell University;

George A. Roberts, Cleveland, Syracuse University; John H. Rosemond, Jr., Columbus, Howard University, Richard R. Waite, Tiffin, University of Michigan; Roman Stetkiewicz, Lorain, University of Jan Kazimierz, Poland.

Supreme Court Rules for Army In Dr. Orloff Case

The U. S. Supreme Court has ruled that it cannot require the Army either to release Dr. Stanley Orloff or commission him. Dr. Orloff was inducted as a private under the Doctor Draft Act. In his subsequent application for a commission he gave incomplete answers to questions in the security oath questionnaire, standing on his constitutional rights. Then he entered suit, demanding that the Army grant the commission or discharge him.

At the outset, the Army contended it was not required to employ Dr. Orloff as a physician. In its Supreme Court brief, however, the Army reversed itself, stating that it accepted the requirement that Dr. Orloff be used in a medical capacity. It said that he was in fact being used as a doctor of medicine, although without all the privileges of a commissioned medical officer. The Supreme Court permitted this reversal of position, then said that two questions remained:

1. Whether Dr. Orloff, as a matter of law, was entitled to a commission.—On this the court decided that the questions of security were enough justification for withholding a commision, commenting: "It is obvious that the commissioning of officers is a matter of discretion (for) the President." Precedent indicates that all physicians serving in the Army should be commissioned, "but if he is the first to be denied a commission, it may also be that he is the first doctor to haggle about questions concerning his loyalty. . . . We are not easily convinced that the whole military establishment is out of step except Orloff."

2. Whether the Federal Courts, by habeas corpus, have power to discharge a lawfully mustered member of the Armed Forces because of alleged discriminatory or illegal treatment in assignment of duties.—The court stated: "Each doctor in the Army cannot be entitled to choose his own duties, and the government concession does not extend to an admission that duties cannot be prescribed by the military authorities. . . . We are convinced that it is not within the power of this court . . . to determine . . . specific assignments. . . . Judges are not given the task of running the Army."

In summary, the Court's opinion stated: "Nothing appears to convince us that he is held in the Army unlawfully, and, that being the case, we cannot go into the discriminatory character of his orders."

Justices Black, Frankfurter and Douglas dissented.

The American Society of X-Ray Technicians will hold its first international convention June 28-July 2, at the Royal York Hotel, Toronto, Canada, in cooperation with the Canadian Society of Radiological Technicians.

Civil Defense . . .

Deadline for Ordering Local Medical Supplies on Matching Basis Near: A.M.A. and Health Department Offer Educational Material

DEADLINE for ordering local civil defense medical supplies on a matching basis from the present allocation by the Federal Civil Defense Administration is April 25.

Ohio's share of this 1953 allocation was established at about $150,000, all available for local use. Orders are placed through the Ohio Office of Civil Defense.

Several items have been added to the original list of purchasable items. Among them are blood extenders, namely PVP Macrose and Dextran.

The recently released Federal Civil Defense Administration annual report reviews progress in medical supply stockpiling, local planning and other phases. According to that agency, when all present orders for federally owned medical supplies and equipment have been delivered, the nation will have stocks sufficient to treat two million casualties for one week. State-held supplies will be enough for 3.3 million persons for the first few hours after an atomic attack.

EDUCATIONAL MATERIAL

For County Society officials and others who wish to stimulate interest in civil defense, a great deal of excellent educational material—some suitable for professional groups and some for general education—is available.

Recent publications regarding civil defense are listed by the Council on National Emergency Medical Service of the American Medical Association as follows:

Handbook for physicians and Nurses—Disaster Preparedness and Relief. The American National Red Cross, Washington, D. C.

Report of the Health and Special Weapons Defense Division, Federal Civil Defense Administration.

Recommended Check-Off List for Hospital Administrators. Prepared by the Medical Health Division, Kansas City Civil Defense Department, Kansas City, Missouri.

"The Public Health Educator in Civil Defense" by Lucy S. Morgan, Ph. D. Reprint from *American Journal of Public Health.*

"The Veterinarian's Responsibility in Civil Defense" by Dr. Daniel Bergsma. Reprint from *American Journal of Public Health.*

A summary of Georgia Civil Defense Health Services Plan, Nov., 1952.

National Blood Program.

"Current Concepts of Burn Therapy" by Dr. Herman Ehrlich. Reprint from *Journal of the American Pharmaceutical Association.*

"A Symposium on Medicine in Civil Defense." Reprint from *The Journal of the Missouri State Medical Association.*

FILMS

A number of films related to the general aspects of civil defense are available without charge from the Ohio Department of Health.

The films are 16 mm. sound, and can be secured by addressing the Division of Health Education, Ohio Department of Health, Ohio Departments Building, Columbus, Ohio. They are as follows:

"Atomic Alert"—black and white—running time, 22 minutes. Here is an important new educational film specifically designed to show children and adults how they can best protect themselves in case of enemy attack with an A-Bomb at home, in the school and on the street.

"Survival Under Atomic Attack"—black and white—running time, 10 minutes. This film is designed not to frighten but to enlighten. It shows and tells six secrets of survival of an atomic attack to be studied and memorized.

"You Can Beat The A-Bomb"——black and white—running time, 45 minutes. First aid film which gives the initial measures to be taken in cases of bleeding, burns, fractures, poisons and shock.

"Firefighting For Householders"—black and white—running time, 15 minutes. Shows how fires begin, how to control them, how to prevent them.

"Cities Must Fight"—black and white—running time, 10 minutes. Here is the answer to all those who belong to the take-to-the-hills fraternity. This film shows why we must not desert our cities in wartime. . . . The clogging of highways would bring all our emergency vehicles to a standstill. . . . Mass evacuation doesn't work. . . . Above all, the film points out that if we desert our cities we have lost the war.

"What You Should Know About Biological Warfare"—black and white—running time, 8 minutes. Defense against invasion includes defense against disease. This film points out the three methods of biological warfare—germs, toxins and plant growth regulators. . . . Biological attack will be aimed at food, livestock and people. Methods of dealing with a disease attack include personal sanitation and efforts of public health authorities.

"Help Wanted" — black and white — running time, 40 minutes. First aid film which gives the initial measures to be taken in cases of bleeding, burns, fractures, poisons and shock.

* * *

A new film entitled "U. S. Civil Defense in Action" is available for purchase. Supplier is Bryan Inc., 1226 Wisconsin Avenue, Washington, D. C. The price is $12.75. This 13-minute film, which is cleared for television, highlights what has been done in civil defense and what must be done. It includes action material of disaster and training operations in Los Angeles, Albuquerque, New York City, and Providence.

Gamma Globulin . . .

Detailed Article on Uses of Serum and on Plans for Distribution Compiled by State Director of Health Porterfield for OSMA Journal

PLANS for the distribution of gamma globulin in Ohio are being developed by the Ohio Department of Health, the official state agency designated by the U. S. Office of Defense Mobilization to handle Ohio's quota of the national supply.

Since the practicing physician plays a vital role in this program, *The Journal* requested Dr. John D. Porterfield, state director of health, to prepare a comprehensive article on this subject.

The excellent article by Dr. Porterfield, which includes all details to date for the distribution and uses of the serum, follows:

IMMUNE serum globulin has been known for some years as being effective in the prevention or modification of measles (rubeola).[1, 2, 3] Its usefulness in the protection of contacts to infectious hepatitis has also been demonstrated.[4, 5] While some study has been given to its protective qualities in other conditions, such as German measles (rubella),[6] its use has been almost entirely for measles and infectious hepatitis.

In October, 1952, Hammon and associates made preliminary report on its effect in the prevention and possible modification of the paralytic manifestations of poliomyelitis.[7] More study is necessary to assess properly the limits and conditions of this new development, but the early figures show a much lower than anticipated incidence of poliomyelitis in the period of one to five weeks after inoculation in those receiving globulin derived from Red Cross blood.

SOURCES OF SUPPLY

Prior to this latest announcement, the supply of globulin has been reasonably adequate to meet demands. There have been two sources of supply. It has been available to physicians in drug stores, being provided through normal commercial channels from drug houses which process it principally from placental blood.

It has also been available to physicians without charge from health departments, through whom it has been distributed as a by-product of the American National Red Cross blood collection program. The Red Cross collects blood from voluntary donors for use of the military forces, civilian hospitals not participating in blood banks, and for the processing of plasma for stockpiling for military and civil defense contingencies. What portion of donated blood is not used currently as fresh blood is fractionized under Red Cross contract.

HAS PROTECTIVE PROPERTIES

The fraction with which we are presently concerned is immune serum globulin. Blood studies have shown that the protective properties heretofore listed are contained in that further fraction of globulin known as gamma globulin. Immune serum globulin contains about 16 per cent gamma globulin.

The information that globulin can prevent the paralytic phases of poliomyelitis has changed radically the supply situation. The widespread public concern with this epidemic disease and its dramatic manifestations has magnified the first whisper of hope for specific protection into a universal clamor for immediate utilization.

Every parent is understandably anxious to provide this safeguard for children. This anxiety has tended to create the general erroneous impression that globulin is more effective than it has yet been shown to be. For that reason, these facts from present evidence must be emphasized:

1. So far only the paralytic manifestations of poliomyelitis have been shown to be affected. The disease may still be acquired *and passed on*. The protected individual may have a non-paralytic case, but the one exposed to him may acquire a paralytic case. Globulin therefore has not been shown to be effective in epidemic control.

2. The paralysis - prevention effects endure only from one week after the globulin injection to a maximum of about five weeks after injection. There may be some modification of paralysis in those cases whose

date of onset is less than one week after globulin injection.

3. The protection is not absolute. For reasons not yet determined, some cases of paralytic poliomyelitis do occur even in the one to five week post-globulin injection "protected period."

4. The dosage used is relatively large, 0.14 cc. per pound of body weight. This means an injection of 7 cc. for a 50 pound child, 10.5 cc. for a 75 pound individual. There is cause to believe that this is at best a minimal dosage level.

5. Globulin from Red Cross blood was used in the studies. This globulin is derived from large pools of whole blood, which represent the antigenic experience of great numbers of people over a wide geographic spread. Uniformly high titers of antibody for all three types of poliomyelitis (there is no cross-immunity between types) have been found in globulin so produced. It is possible that commercial globulin, if derived from small pools of (placental) blood, may have less uniformly high titers and be, thereby, less effective in protection against poliomyelitis.

EFFORTS TO INCREASE SUPPLY

The supply of globulin cannot be immediately increased to the extent that the demand has increased. There are two limitations—the supply of whole blood available for processing and the capacity of existing processing plants. The Red Cross is expending additional money and effort to increase blood donations and physicians are urged to support this intensified program. The processing plants, on their part, have gone on a 24 hour day, 7 day week production program and serious efforts are being made to expand processing capacity.

This involves not only financial investment, but also the obtaining of intricate equipment and carefully trained personnel. With the best efforts of all concerned, the supply of globulin will be seriously short of the demand at least during 1953, if not longer.

In view of this situation, the Office of Defense Mobilization, which has controlled blood as a critical item essential to the national defense for some time, has announced the controlling of gamma globulin and proposes to allocate the total supply by methods which will offer the best effect from the amount available.

ODM TO REGULATE GLOBULIN

The American National Red Cross has announced that all globulin production under its contracts will be turned over to the Office of Defense Mobilization. The National Foundation for Infantile Paralysis has announced that it will purchase all globulin produced not under Red Cross contract and will turn it, too, over to ODM. After what globulin presently in retail commercial hands has been expended privately, all future use will be within the regulations established by ODM.

Here, then, we come to the aspect affecting all components of medicine—how ODM may best dispose the globulin supply to provide greatest good to the greatest number. The first move by ODM has been to seek the scientific counsel of the National Research Council. The NRC's Division of Medical Sciences has in turn appointed a Panel on Allocation of Gamma Globulin to develop recommendations.

ACTIONS OF ODM TO DATE

For the past three months that panel has been at this task, considering the scientific basis upon which the best system may be established and reviewing it in the light of the interests of all concerned bodies.

To date, ODM has taken these actions based on recommendations submitted:

1. All globulin will be distributed through state health departments. This permits decentralization of the allocation program while still retaining official responsibility.

2. Each state will receive a supply of gamma globulin for use in prevention of measles and infectious hepatitis. The amount for this purpose to each state will be 3 cc. times the average annual number of measles cases reported in the five year period 1947-51. Both measles and hepatitis protection must be provided from this supply. (Ohio's five year measles average was 21,400 cases, which will provide 64,200 cc. of globulin for these uses in the remainder of 1953.) Since measles, and particularly infectious hepatitis, have probably been under-reported, close rationing will be necessary even in this program. Physicians are urgently requested to restrict the use of gamma globulin to those susceptible individuals exposed to measles, who have valid medical indications for prevention or modification, and to household contacts of infectious hepatitis.

3. Each state will receive a basic allocation of globulin for use in protection from poliomyelitis paralysis. This amount will be 40 cc. times the average annual number of poliomyelitis cases reported in the five year period 1947-51. This supply may be used for protection of intimate contacts of diagnosed cases in such fashion and with such records as each state shall determine to be necessary. This basic allocation may be supplemented if 1953 reporting indicates conditions greater than average. (Ohio's five year average was 1,481 cases times 40= 59,240 cc. in the basic allocation.)

4. The remaining supply of gamma globulin will be retained by ODM for distribution

in unusual, emergency and epidemic situations. The terms of such situations are presently being considered by NRC's Panel and ODM and early announcement can be expected.

GUIDING CONSIDERATIONS

The major problem in establishment of this system has been to determine from the evidence at hand that portion of the population most liable to poliomyelitis infection. The more closely this can be identified, the higher the "preventive potential" of any specified amount of globulin.

When a community has reached an incidence of high epidemic level, the virus is widespread in the community and protection of all of the susceptible age group in that community would be efficient. This is the fashion in which Hammon's field studies were done. However, if the community is quite small, premonitory statistics are not reliable.

If the community is quite large, the practical aspects of "community prophylaxis" and the amount of the restricted supply which could be expended at one time and place raise serious difficulties. Prior to epidemic levels, when cases in a community are reported at a low endemic level, the greatest risk is in those susceptibles immediately around a case.

Establishing a protection zone among the contacts of each case seems reasonably the most effective use. If all actual cases could be identified, it should be highly effective. Short of that, contacts of diagnosed cases should be given the earliest possible protection. These are the considerations which will guide establishment of the final rules.

Meanwhile, the Ohio Department of Health has received and begun to distribute to local health departments the first part of the globulin allocation for measles and infectious hepatitis. The basic allocation for poliomyelitis will begin to be received about May 1.

ADVISORY COMMITTEE APPOINTED

To devise within Ohio the most practical and effective means of utilizing Ohio's supplies within the conditions imposed by ODM, an advisory committee on allocation has been named. Its members are: Mr. W. K. Dunton, Piqua, (Ohio Congress of Parents and Teachers, Inc.); Dr. Thomas R. Curran, Columbus, (Ohio State Medical Association); Dr. O. M. Goodloe, Columbus, and Dr. W. W. Lawrence, Norwalk, (Local Health Commissioners); Dr. Anthony Ralph Marsicano, Columbus, (Ohio Academy of General Practice); Dr. Warren E. Wheeler, Columbus, (Poliomyelitis Treatment Centers). Its first meeting was on March 25, the day after the most recent meeting of the National Panel on Allocation with ODM. From these two meetings will come in the immediate future further detailed information.

It is fully appreciated that the practicing physician holds the key role in this program, both in providing factually correct information to parents and in actual administration of the protective inoculations. His cooperation is indispensable and is earnestly solicited.

FOR MEASLES AND HEPATITIS

The system for distributing immune globulin for use in measles and infectious hepatitis was explained in a memoramdum to all health commissioners, dated March 12.

Under the plan, there is being shipped to each health jurisdiction an initial allotment of immune globulin which will equal about one-half of the average amount supplied during the month of March in the years 1951-1952.

After the initial allocation, no further shipments will be made except on request directed to the Division of Laboratories by the health officer. Excluding March, these requests will be honored up to the maximum amount allowable under the allocating formula which will be equal to one-half the average granted to the health jurisdiction for the corresponding month in 1951-1952.

This plan allows a small working reserve which is intended for use in areas where unusual situations may arise during the remainder of the year. Arrangements under these conditions are to be worked out between the health commissioner involved and the Division of Communicable Diseases of the Ohio Department of Health.

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Obstetrics and Gynecology Board To Give Examinations

Examinations of the American Board of Obstetrics and Gynecology, Part II (oral and pathological), will be given at the Edgewater Beach Hotel, Chicago, May 17 through May 24. Applications for the 1954 (Part I) are now being received and should be in by August or September.

Candidates for Part I are reminded that the Board now requires them to submit lists of all patients for whom they are solely responsible for the year preceding their applications or the year prior to their request for reopening of application, with information.

Additional information may be had from: Dr. Robert L. Faulkner, secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Rd., Cleveland 6, Ohio.

FSA Reorganization Plan . . .

Eisenhower Proposal for Cabinet Department of Health, Education and Welfare Wins A.M.A. Approval, With Reservations; Speedy Action Sought

BY the time this issue of *The Journal* reaches its readers, the Congress may have approved a plan to convert the Federal Security Administration into a U. S. Department of Health, Education and Welfare with cabinet status.

This is called for under Reorganization Plan No. 1 submitted by President Eisenhower. The proposal calls for a Special Assistant for Health and Medical Affairs in the new department which presumably would be headed by Mrs. Oveta Culp Hobby, the recently named F. S. A. administrator. The wording of the proposal implies that the special assistant would be a doctor of medicine, appointed by the President.

On March 17, the reorganization proposal was approved by the House Committee on Government Operations by a vote of 17 to 12. It was approved by the House of Representatives by a vote of 291 to 85 on March 18. At this writing it was in the hands of the Senate Committee on Government Operations for action. If approved by the Senate, it would become effective within 10 days.

SPECIAL A. M. A. SESSION

Prior to action in the House, on March 14, the House of Delegates of the American Medical Association met in special session in Washington, D. C., to consider this one issue.

By a unanimous vote the A. M. A. House of Delegates adopted a report from the Board of Trustees supporting the reorganization plan as a "step in the right direction" but at the same time reaffirming the A. M. A. position in favor of the ultimate formation of an independent Department of Health. During the proceedings, many delegates expressed disappointment that a full-fledged investigation and study of the Social Security Program could not have been undertaken and completed before steps were taken to elevate the F. S. A. to department and cabinet status.

ADDRESSED BY EISENHOWER

The A. M. A. House of Delegates was addressed by President Eisenhower. He reminded the Delegates that his administration was in philosophic accord with them, then declared: "We thoroughly understand the importance of your functions. . . . We also understand, and are determined to meet the requirements of our population in the services that only you can provide . . ." He said the medical profession could do its job better "with the cooperation and friendship of the administration," and pledged that his administration wouldn't attempt to direct medical care" or to be the 'Big Poobah'."

Others who urged the delegates to approve Plan No. 1 included Senator Taft and Rep. Walter Judd; and Drs. Bauer, Henderson, and Murray. Among arguments made by the speakers were: 1. This is the first plan to recognize medicine at the top level of a proposed Department. 2. Organizationaly it is an improvement over F. S. A. in providing for medical programs. 3. It would give the Secretary greater authority in placing new people in policy-making jobs.

TEXT OF A. M. A. STATEMENT

Following is the text of the statement of policy on the issue which was adopted by the House of Delegates:

The House of Delegates of the American Medical Association has for nearly 80 years been on record as favoring an independent Department of Health in the Federal government. The reason for this stand has been that the House has felt that health and medicine should be given a status commensurate with their dignity and importance in the lives of the American people, and that they should be completely divorced from any political considerations.

The Board of Trustees, after a careful study of the policy of the American Medical Association with respect to the administration of health activities in the Executive Branch of the government and after studying the Reorganization Plan for elevation of the Federal Security Agency to cabinet status submitted by President Eisenhower to the Congress, finds that Reorganization Plan No. 1 of 1953 provides for a special assistant to the Secretary for Health and Medical Affairs. This provision is a step in the right direction which should result in centralized coordination under a leader in the medical field of the health activities of the proposed department. Health, therefore, is given a special position. The proposed plan, properly administered, will permit more effective coordination and administration of the health activities of the new Department without interference or control by other branches.

Previous attempts to raise the Federal Security Agency from an independent agency to the level of an Executive Department have been opposed by the Association because the plan did not meet these aims.

Inasmuch as Federal health benefits and programs are established by the Congress, an administration bent on achieving the nationalization of medicine cannot reach that goal except with the support of Congress. Therefore, an organizational plan through which Federal health activities are administered, although important, is not nearly so vital an issue as the policies adopted by the Congress of the United States.

The Board of Trustees recommends that the

House of Delegates reaffirm its stand in favor of an independent Department of Health but that it support the Reorganization Plan No. 1 of 1953 as being a step in the right direction; that the American Medical Association cooperate in making the plan successful and that it watch its development with great care and interest.

It should be understood, however, that the Association reserves the right to make recommendations for amendment of the then existing law or to press for the establishment of an independent Department of Health, if the present plan does not, after a sufficient length of time for development, result in proper advancement in and protection of health and medical science and in their freedom from political control.

SPECIAL ASSISTANT'S DUTIES

A detailed explanation from President Eisenhower's office describing the functions and responsibilities of the Special Assistant on Health and Medical Affairs, an office which will be created if the reorganization plan becomes effective, was furnished the A. M. A. delegates prior to the time action was taken. Excerpts from this specially prepared statement from the President's office are as follows:

The Special Assistant to the Secretary will be the top staff policy adviser to the Secretary with respect to health and medical matters. He will have responsibility for reviewing the health and medical programs throughout the Agency and, where necessary, making recommendations for improvement. On matters of legislative policy where health and medical policies are involved, he will be responsible for making recommendations to the Secretary. This will include review of legislative reports involving health and medical care matters, proposed testimony before Congressional committees relating to health and medical care matters, and other related policy statements such as annual reports, etc.

As chief staff policy adviser in the health and medical field, the Special Assistant to the Secretary will represent the Secretary on top level interdepartmental committees concerned with health and medical care matters, such as the Health Resources Advisory Committee to the President. He will have responsibility for liaison on behalf of the Secretary with important nongovernmental groups, such as the American Medical Association, the American Dental Association, the American Hospital Association, the American Public Health Association, and the Association of State and Territorial Health Officers.

The Special Assistant to the Secretary will, from time to time, represent the Secretary at various international meetings, such as being a delegate to the World Health Assembly of the World Health Organization, and other major international assignments.

As directed by the Secretary, the Special Assistant to the Secretary will see that related health and medical problems arising in any of the various constituents having health or medical care programs are properly coordinated.

In short, the Special Assistant to the Secretary will be the top staff policy adviser to the Secretary on health and medical matters, will represent the Secretary in important external relationships of the Department with national and international bodies concerned with health and medical matters, and will, as needed, coordinate related health and medical programs within the Department.

WHAT WENT ON AT HEARING

A sideline description of what took place on this question up to the time this issue went to press is found in the following excerpts from a bulletin from the Washington Office of the A. M. A. dated March 20:

The House vote on Reorganization Plan No. 1 saw a number of members settling down in places where, from their past records, you'd never look for them. For example, some of the 85 nays announced in advance they favored the plan and were voting only against the legislative technique used to expedite establishment of the new department. Grouped with them in the nay column were others who consistently oppose centralization of authority. Likewise among the 291 yeas there was a mixed pattern. Many of these votes were an out-and-out expression of confidence in the Eisenhower administration. But a large bloc of them were cast for other reasons. So the rollcall can't begin to tell the story of who voted for what and why. From now on the course of the Reorganization Plan may be complicated but it's not likely to be stormy; it is not so much a question of whether the new department will be set up but when.

Senate and House Committees on Government Operations, meeting jointly, devoted one long day's sessions to President Eisenhower's plan. Principal witnesses were Joseph M. Dodge, director of the Bureau of the Budget; Mrs. Hobby, and three witnesses for A. M. A., former Presidents John Cline and Elmer Henderson, and Dr. Dwight Murray, chairman of the Board of Trustees.

Mr. Dodge said the plan carried out the accepted business practice of creating positions of authority, then filling them with capable people.

DIFFERS FROM TRUMAN PLAN

Twice Congress rejected Truman plans for a three-way department. Democratic members of the joint committee argued that there wasn't much difference between them and the 1953 plan. However, Mr. Dodge said that while this plan is similar to the 1950 plan, it is basically different from the 1949 plan. Furthermore, he, Mrs. Hobby and the A. M. A. spokesmen emphasized that the top level position of Special Assistant to the Secretary (for Health and Medical Matters) was not contained in any other plan ever submitted to Congress.

Senator Humphrey and several other committee members wondered if the post of Special Assistant to the Secretary for Health and Medical Matters wasn't a concession to the medical profession,

and particularly to A. M. A. Dr. Henderson said this official would be able to guard against socialized medicine by "making recommendations to the Secretary." Rep. Judd made this reply: "This position was created so the people who have provided the best medical care in the world will be able to continue to provide the best medical care in the world." Mrs. Hobby explained that the Special Assistant would advise her, but that he wouldn't have any administrative authority over the Surgeon General of Public Health Service.

New Exhibit Shows How Medical Dollars Are Spent

A new exhibit showing how the medical care dollar is distributed among physicians, hospitals, druggists, dentists and others is now available through the American Medical Association's Bureau of Exhibits. "Where Your Medical Dollar Goes" features three-dimensional figures on a revolving pedestal. Available to state and county medical societies, this exhibit may be shown either in conjunction with such exhibits as "Health Today" and "Your Medical Care" or by itself.

Federal Legislation . . .

Explanation of Some of the Bills Now Pending Before Congress and The Position of the American Medical Association on Some of Them

FOLLOWING is a roundup as of March 20 of some of the more important bills which have been introduced into the present U. S. Congress and the policy of the American Medical Association on those which have been reviewed by A. M. A. officials to date:

S. 1153 (Ives, R.-N. Y.). and Flanders, R.-Vt.). **Federal Aid to Voluntary Health Plans, Medical Education and Health Facilities.** In accord with recommendations of the now defunct Truman Health Commission, this bill would provide federal funds to: (1) assist states in financing voluntary prepayment health service plans with subscription charges based on subscribers' income; (2) encourage establishment of local administrative health regions and districts; (3) enable non-profit hospitals, medical schools, and nursing schools to maintain and improve their service facilities; (4) assist voluntary prepayment plans to build and equip personal health centers; (5) assist medical education; and (6) assist local public health units. The Surgeon General would carry out the federal part of the program and would make administrative regulations after consultation with a Federal Health Council of ten persons (no physicians) appointed by the Administrator of F. S. A.

Identical bills were introduced in the House: H. R. 3582 (Hale, R.-Maine) and H. R. 3586 (Javits, R.-N. Y.) In addition, Senators Ives and Flanders introduced S. 1154 providing that persons in computing personal income taxes could deduct the cost of health insurance subscription charges for qualified health insurance plans described in S. 1153. Bills identical with S. 1154 were introduced on the same day: H. R. 3583 (Hale) and H. R. 3585 (Javits). Bills similar to all of those above referred to were introduced in 1949 by the same authors.

H. R. 3473 (Doyle, D.-Calif.). **To establish a Federal Agency for Handicapped.** Identical with H. R. 2096 (Hagen).

H. R. 3487 (Lane, D.-Mass.) **To Extend Social Security Coverage.** Would amend the present law to bring additional persons under the social security insurance system. Self-employed persons to be covered would include physicians, lawyers, dentists, osteopaths, veterinarians, chiropractors, optometrists, Christian Science practitioners, architects, accountants, funeral directors, and professional engineers.

H. R. 3554 (Zablocki, D.-Wis.). **Total and Permanent Disability Insurance.** Would amend the social security law to provide disability insurance benefits for periods of total and permanent disability. The bill does not specify how total and permanent disability would be determined.

H. R. 3850 (Mrs. Frances P. Bolton, R.-Ohio). **Federal Aid to Nursing Education.** Provides a three year program of Federal aid to graduate nurse training and practical nurse training. The Surgeon General of the Public Health Service would make regulations for the graduate nurse program. The Commissioner of Education would have a similar role in the practical nurse program. Funds could be used for instruction, for scholarships, for administrative expenses of the states, and for recruiting students.

S. 70 To Recognize Medical Military Service in the Armed Forces of Co-belligerent Nations. Active approval by A. M. A.

S. 93 Federal Aid to States to Subsidize Voluntary Health Insurance Plans. Active opposition by A. M. A.

S. J. Res. 1 Proposing an Amendment to the

Constitution Relative to the Making of Treaties. **Active approval by A. M. A.**

H. R. 8 Federal Hospitalization for Aged Social Security Beneficiaries. Active opposition by A. M. A.

H. R. 9 Giving Effect to Waiver of Premiums for Disabled Social Security Beneficiaries. Active opposition by A. M. A. for following reasons: (1) A. M. A. favors adoption of formula for computing OASI insurance benefits based on a wage-earner's best 5 or 10 years, thus obviating necessity for special consideration in cases involving permanent and total disability; (2) waiver of premium provision has not been thoroughly explored; (3) although state agencies would administer the program, the Federal Security Agency would set over-all standards and regulations; and (4) intervention by Federal government in this phase of medical activity would be a further interference in the field of private medical care.

H. R. 10 Tax Deferral for the Establishment of Voluntary Pension Plans for Self-employed Persons. Active approval by A. M. A.

H. R. 173 Hospitalization and Medical Care for Dependents of Members of the Uniformed Services. Active opposition by A. M. A. which is concerned over the unauthorized expansion of a dependent medical care program and requests that a congressional determination be made as to whether such benefits are proper emoluments of military service. The Association is also concerned over the drafting of a great number of physicians to be used to a large extent in providing medical care for other than military personnel.

H. R. 301 To Establish a Department of Health. Active opposition by A. M. A. which favors the proposed Federal Board of Hospitalization.

Annual Report of Medical Board

Annual report of the State Medical Board for the year 1952 shows that the two inspectors of the Board investigated 205 complaints of illegal practice during the 12-months period and made 1,892 calls into various parts of the state.

Forty-five cases were filed in court; one case dismissed; 18 cases awaiting trial and 17 cases pending from previous years were concluded. Fines were assessed in the amount of $4,125, of which $850 were suspended. Collection of fines in other cases were held in abeyance pending decision of higher courts to which the cases were appealed.

During the year the board issued licenses following examination to 327 doctors of medicine; 52 osteopaths; and 113 limited practitioners. On endorsement from other states, the board issued licenses to 284 doctors of medicine and two osteopaths.

Sponsor Essay Contest on Physical Medicine and Rehabilitation

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation will award annually a prize for an essay on any subject relating to the field. The contest, while open to anyone, is primarily directed to medical students, interns, residents, graduate students in the pre-clinical sciences and graduate students in physical medicine and rehabilitation.

Additional information may be had from the Congress at 30 N. Michigan Ave., Chicago 2.

Cleveland Academy Sponsors Meeting for Receptionists

A public relations clinic for medical receptionists, secretaries and office nurses will be sponsored by the Academy of Medicine of Cleveland on April 8 at the Hotel Cleveland.

Subjects to be covered include office procedures designed to build good will of patients, grievances which the receptionist can help to eliminate, good telephone techniques, correct procedures in filling out insurance forms, billing practices and policies, letter writing and similar subjects.

Rocky Mountain Cancer Conference To Be Held July 8-9

The Seventh Annual Rocky Mountain Cancer Conference will be held in Denver, Colorado, July 8-9. As in previous years, there will be eight outstanding guest speakers, and on the first evening a banquet and entertainment for both the doctors and their ladies. There is no registration fee. Additional information may be obtained from office of the Colorado State Medical Society, 835 Republic Building, Denver 2.

Two Medical Scholarships Are Bequeathed by Doctor

Two $1,000 scholarships to Ohio State University College of Medicine were designated in the will of the late Dr. Floyd F. Ayres, of Akron. Dr. Ayres, who formerly practiced at Hinckley in Medina County, designated that the recipients be interested in country practice. He also left his large residence with the request that it be used as a branch library.

Good Samaritan of Zanesville Launches Expansion Program

The Good Samaritan Hospital, Zanesville, on March 19 launched a drive to raise 1½ million dollars toward the construction of a new wing and rehabilitation of the present building. The entire project will cost an estimated 2½ million dollars.

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DESERVING PRAISE GIVEN MERCER COUNTY DOCTORS

Three cheers for the Mercer County Medical Society!

Also, congratulations to Mr. Jerry Ahlers, who is the author of the following letter to the Columbus Office of the Ohio State Medical Association.

By their actions, the physicians in Mercer County are making a real contribution to public health and have scored a ten-strike in public relations.

Too often those receiving help and assistance from physicians—others, also—fail to pass out bouquets.

Writing as executive secretary of the Mercer County Unit, Ohio Division, American Cancer Society, Mr. Ahlers has this to say about the doctors in that county:

"Too often, the public and individual organizations 'take for granted' the many hours and efforts their local Doctors give 'Beyond their Line of Duty.'

"The Mercer County Cancer Service has in its file a folder marked 'Give Credit Where Credit is due.'

"We want it known that our Organization feels greatly indebted to the Mercer County Medical Society for the interest and cooperation it has shown in our activities and projects.

"Last month they viewed the new professional film, 'Uterine Cancer' as per the enclosed newspaper article and all of them are now making it possible for the public to obtain in their waiting rooms the pamphlet, 'Things You Should Understand about Cancer Examinations' as recommended by Dr. C. E. Hufford, Chairman, Sub-Committee on Cancer, O. S. M. A.

"They have all been furnished Pap Kits by our Unit and several have offered to be available at different Educational Film Showing programs we have scheduled.

"The cooperation and assistance they have given us is so greatly appreciated that we are asking that they be given recognition by letter, publication or whatever way (if any) that it can be extended them."

A LITTLE ORGANIZED EFFORT DOES THE BUSINESS

Piqua physicians who for years have donated their professional services in relief cases, now will be paid for their efforts, according to a news item in the *Piqua Call.* The article points out that the city fathers adopted a resolution providing for a scale of fees to be paid in authorized relief cases. We suspect some good work by the Miami County Medical Society. Yep, it takes a little organized effort to get things accomplished these days. What's your society doing?

COORDINATION OF POSTGRADUATE AND REFRESHER ACTIVITIES

The Cleveland Academy of Medicine has launched a move to coordinate the postgraduate and refresher activities and programs being presented in Cuyahoga County for the benefit of the physicians of the county.

Now, scores and scores of meetings by scores and scores of organizations, institutions and groups are being held each month. There is overlapping and duplication of subjects and speakers. Conflicts have occurred. The time of busy physicians has been imposed upon, and in some instances wasted.

The Academy's plan is to try to get all of the groups to cooperate and to coordinate their programs. Long-range planning can be engaged in. Fewer meetings will have to be held but physicians will be exposed to the same subjects and given the same opportunities to keep themselves posted.

It's a swell idea. Should be tried elsewhere where duplication exists and where too many meetings are being held. It should increase attendance at the meetings decided upon and stimulate interest generally.

BEDS AVAILABLE BUT PEOPLE WON'T USE THEM

Toledo newspapers report that more than half the beds in the Maumee Valley Hospital are vacant—something almost unheard of in these days of hospital bed shortages. Other hospitals in Toledo are overflowing.

The Toledo Blade states that people feel there is a stigma attached to entering a hospital where charity patients also are treated, despite the fact that the institution is one of Toledo's best in all categories.

People are funny. They're one reason why doctors and hospital superintendents acquire gray hairs prematurely.

GOOD ADVICE IN DEALING WITH NARCOTIC ADDICTS

Physicians cannot be over-cautious in the handling and prescribing of narcotics, especially if the patient is suspected of being an addict. Sound advice is contained in the following, which is based on a communication issued by the Bureau of Legal Medicine of the American Medical Association. Read it carefully. Follow the advice and suggestions offered.

The Harrison Narcotic Act does not deny to

Inhibition of Excess Parasympathetic Stimuli in Peptic Ulcer with Banthine®

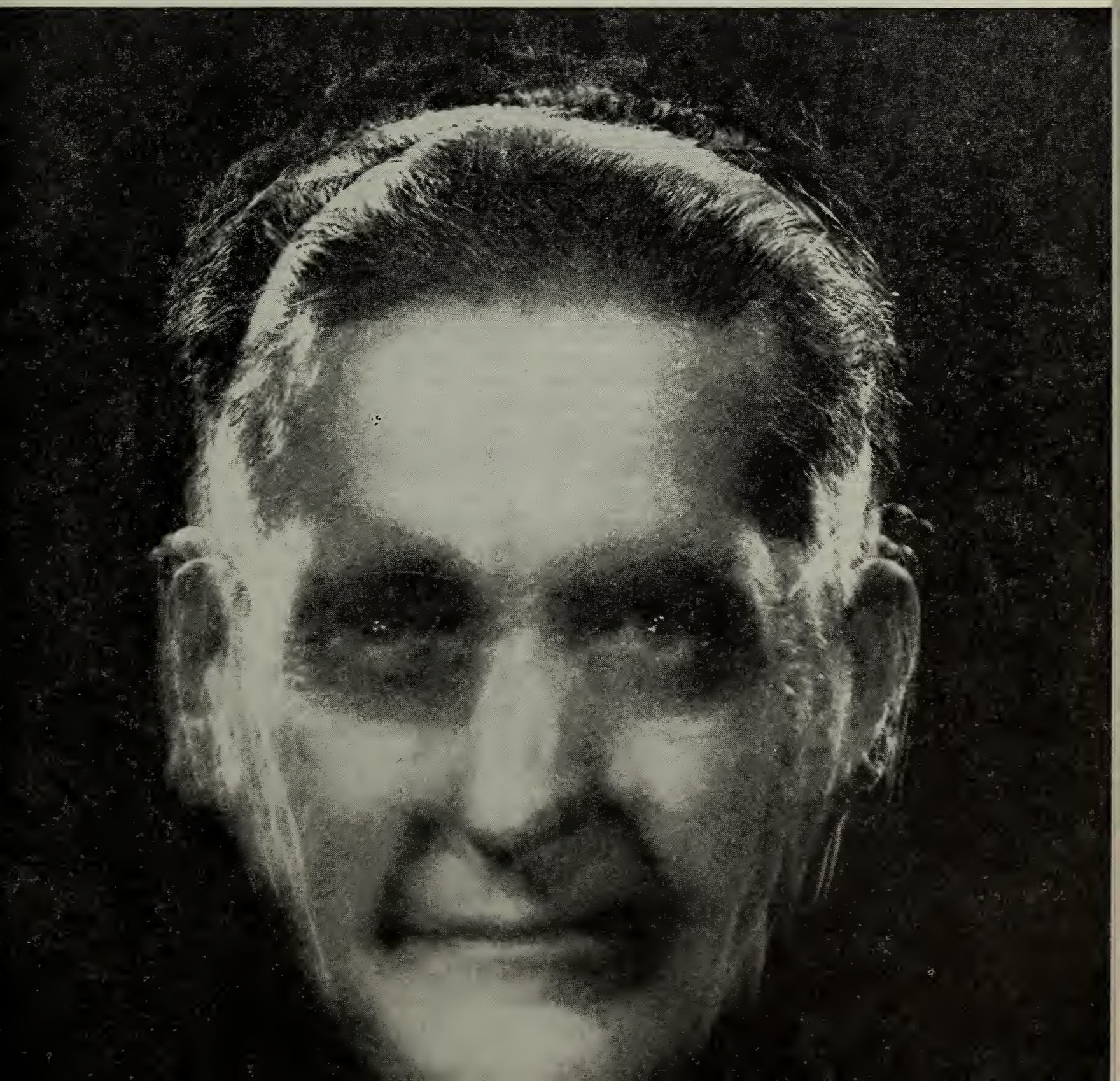
Medical literature now contains more than 200 references to the beneficial role of Banthine Bromide (brand of methantheline bromide) as evidenced by a marked healing response of peptic ulcers. Rapid symptomatic improvement, particularly with reference to pain relief, is followed by roentgenographic demonstration of crater filling.

The therapeutic action of the drug in decreasing hypermotility and hyperacidity, together with the remarkable early subjective benefit, is indeed a desired approach in ulcer management.

Treatment is individualized to the patient's needs. One or two tablets (50 to 100 mg.) is administered every six hours, around the clock, in conjunction with appropriate diet control and antacid medication as indicated.

Banthine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle: Research in the Service of Medicine.

Ulcer Facies Composite



a physician the right to administer or prescribe narcotics to a patient who is an addict provided the narcotics are not prescribed or administered merely for the purpose of satisfying addiction. In other words, legally a physician may treat a narcotic addict but cannot supply narcotics for the sole purpose of catering to the patient's addiction.

Any method of treatment for narcotic drug addiction, whether private, institutional, official or governmental, which permits the addicted person to dose himself with the habit-forming narcotic drugs placed in his hands for self-administration, is an unsatisfactory treatment of addiction, begets deception, extends the abuse of habit-forming narcotic drugs, and causes an increase in crime.

The only proper and scientific method of treating narcotic drug addiction is under such conditions of control of both the addict and the drug, that administration of a habit-forming narcotic drug must be by, or under the direct personal authority of the physician, with no chance of any distribution of the drug or addiction to others, or opportunity for the same person to procure any of the drug from any source other than from the physician directly responsible for the addict's treatment.

A physician who does prescribe or administer narcotics to a patient who is an addict does invite suspicion that he may be catering to the patient's addiction. If the patient will not submit to treatment in an institution, possibly the safest course for a physician to pursue if he feels it desirable to give treatment for the patient's addiction is to obtain the patient's consent to discuss the case with the local narcotic officials, explaining the treatment that will be given. While it will not be necessary for the physician to obtain the consent of the narcotic officials to treat the patient, such a course of action will stand a physician in good stead if any question arises in the future concerning the matter.

WHY NOT JOIN YOUR LOCAL CHAMBER OF COMMERCE NOW?

A recent issue of *The Journal of the A. M. A.* carried a letter from the president of the American Chamber of Commerce Executives stressing the need and desirability for close partnership between members of the medical profession and businessmen generally in efforts to try to meet the great social and economic issues of the day.

As Mr. Stanley Draper, president of the A. C. C. E. pointed out physicians should actively participate in the programs and activities of their local chamber of commerce.

We recommend this to Ohio physicians. Join your local chamber of commerce and take part in its work. You're on the same team. It's your community. Make it the best.

Office Public Relations For the Busy Physician

Editor's Note: In order to provide tips for physicians in regard to good Public Relations procedures and practices in their offices, *The Journal* will present from time to time concise articles based on suggestions and recommendations made at A. M. A. Public Relations conferences and on articles published in other medical journals.

The first in the series follows:

FRANKNESS WITH FEES

Doctors' fees should not be permitted to enter the realm of the mysterious. The sensible patient will ask, "How much will this cost me?"

There are others who require a gentle push into a discussion of the financial aspects of a medical or surgical situation, and the physician must sometimes take the initiative.

By talking with the other practitioners in the community, the young doctor can learn what the going fees are for various procedures, and what, if any, variations are made.

As a rule, he should not undercut the average charge in his community, nor go too far above it. Some physicians believe that if a patient cannot pay, it is better that his fee be canceled than "marked down."

Many times it is wise to help the patient budget his fee. For example, on the first visit, an obstetrician might tell the patient, "My charge for this type of case is $10 for the first visit, and 15 dollars a month for six months. This will include two months' follow-up care after the baby is born, barring some unusual or complicated happenings. Is this arrangement satisfactory to you?"

Physicians may also help patients budget their medical expense by recommending Blue Cross hospitalization and Blue Shield surgical insurance, or similar insurance handled by any of the reputable companies in the health and accident field.

It is recommended that physicians display the American Medical Association placard addressed "To All My Patients," inviting fee discussions. To avoid misunderstandings, it is recommended that physicians itemize statements.

One physician recently stated: "The money we collect from our patients must always be reverently regarded as only a partly satisfactory medium by which patients can express their grateful hearts and souls, and we doctors must, in humility, accept fees for acting as guides to Divine Providence and His works."

The failure to consider at all times what is best for the patient from the standpoint of diagnosis, treatment, and fees, is, he said, "unpardonable."



they could stage their own symphony

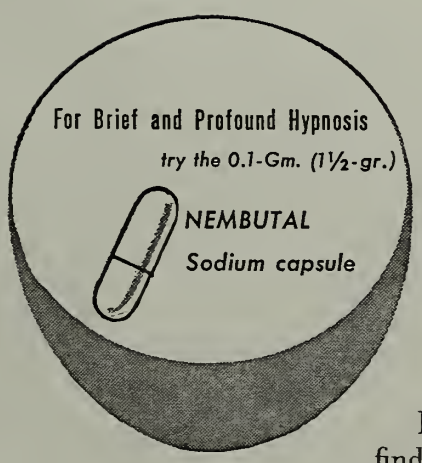
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1. Short-acting NEMBUTAL can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis.
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1-126

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

FOLLOWING press reports of high incidence of homologous serum jaundice (hepatitis) among U. S. troops receiving plasma, Armed Forces Medical Policy Council and Army Surgeon General's Office presented the following statistics: (a) Twenty-three per cent of the severely wounded receiving 5 to 10 units of plasma contract hepatitis from 60 to 180 days after infusions, but mortality is only one in 1,000 cases, (b) while serum albumin has been found free of hepatitis virus, there isn't enough supply to replace plasma, (c) a National Research Council committee is working on sterilization of plasma, but until it arrives at a solution, use of plasma will be continued by the services.

* * *

The House Veterans' Affairs Committee expects to give special attention to hospitals in its forthcoming investigation of Veterans Administration installations. The House has approved a resolution giving the committee power to conduct an inspection of the V. A. and has ordered that it report back with any remedial legislation during the present Congress.

* * *

Dr. Thomas Henry Alphin has joined the American Medical Association's Washington office and will perform contact work with members of the House. Dr. Cyrus H. Maxwell continues as liaison with the Senate. Dr. Alphin came to the A. M. A. from the health division of the Federal Civil Defense Administration. He was formerly a member of the medical faculty of the University of Virginia and assistant chief medical examiner for the State of Virginia.

* * *

A bi-partisan commission of Congressional, Federal, and state officials has been authorized to make an extensive study, then recommend legislation, on Federal-State relations in the fields of taxes and health and social security. Formed at the suggestion of President Eisenhower, the commission is expected to complete its work within the year.

* * *

Among those testifying in support of the Bricker Resolution (S. J. Res. 1) before a Senate Judiciary subcommittee were Dr. George Lull, secretary and general manager of the A. M. A., and W. L. McGrath, a Cincinnati industrialist, representing the U. S. Chamber of Commerce. This bill proposes an amendment of the Constitution to prevent abridgement of domestic rights by international treaty. Due to a set of "Minimum Standards of Social Security" adopted by International Labor Organization last June, the freedom of medicine is jeopardized until the Bricker resolution becomes effective.

* * *

Government statisticians estimate that the average urban family spent 4.7 per cent of all its expenditures on medical care in 1952. The Bureau of Labor Statistics has divided family spending as follows: 30.1 per cent for food; 32 for housing; 9.7 for clothing; 11 for transportation; 4.7 for medical care (including health insurance costs); 2.1 for personal care; 5.5 for reading material and television; 5 per cent for other goods and services.

* * *

An initial decision rendered by Federal Trade Commission against Miracle Hearing Aid, Inc., East Orange, N. J., orders discontinuance of advertising claims that the device enables the deaf to hear, that it is of any value as a hearing aid, that physicians have approved "Miracle Hearing Aid."

* * *

The Federal government loses perhaps as much as $75 million annually in payments to ineligibles kept on state rol's of needy aged, dependent children, the blind, and totally disabled according to an estimate of a Senate investigator who spent months looking into the Federal Security Agency's Bureau of Public Assistance.

* * *

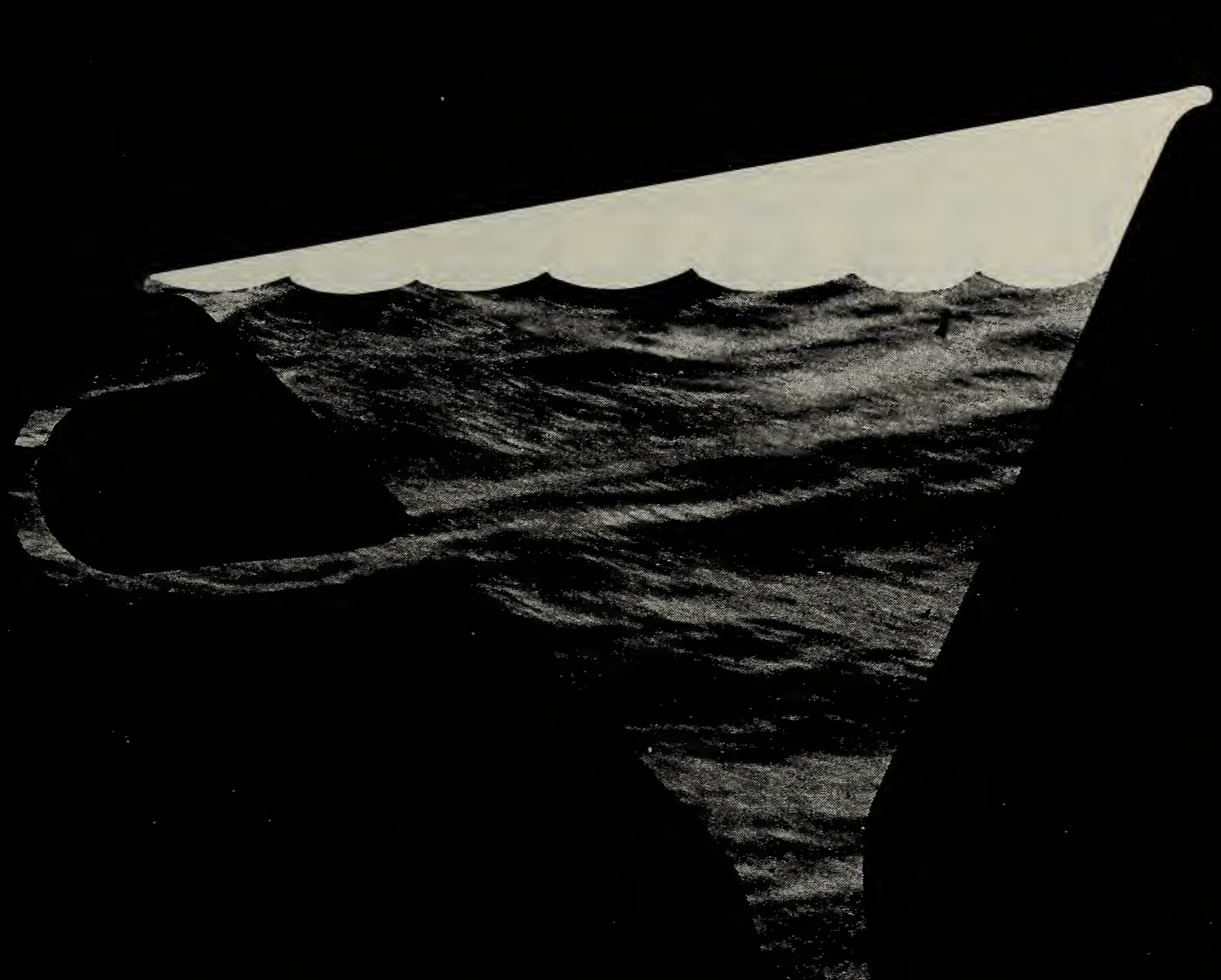
A legal stipulation between Federal Trade Commission and the Predicator Corp. of Norwalk, Conn., terminates advertising claims that a calendar-slide device, "Predicator," provides an unfailing system of spacing births.

* * *

Jack Beardwood, 38-year-old former newspaper man and at one time an aide to General Mark Clark in World War II, has been selected by Federal Security Administrator Oveta Culp Hobby as assistant in charge of legislative liaison and public relations coordination.

* * *

Charles W. Crawford, Commissioner of Food and Drug Administration, said that there is a great need for a clearing house of information in injuries attributed to administration of drugs in a recent address before a New York legal



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group. He also stated that his agency intends to continue bearing down on medical quacks, especially those victimizing cancer sufferers.

* * *

The Office of International Trade, Department of Commerce, has named a special "task force" drawn from leaders in the drug industry, to investigate diversion of sulfonamides and antibiotics from West European consignees to purchasers in "iron curtain" countries.

* * *

Two new civil defense consultants have been added to the Council on National Emergency Medical Service, Dr. Edgar M. Dunstan of Atlanta, and Dr. Carrol P. Hungate of Kansas City, Missouri. Both have made outstanding contributions to civil defense efforts on a state and local level.

* * *

Just published by Federal Civil Defense Administration is its technical manual on setting up a first aid system (evacuation and treatment). The 52-page booklet (TM-11-1, Part 1) is purchasable from Superintendent of Documents, Washington 25, D. C., for 20 cents.

NBC Again Carries Programs Produced by A. M. A.

For the second consecutive season, the National Broadcasting Company radio network is carrying a series of six public service programs produced by the American Medical Association. Six top-notch radio and stage stars are featured in the half-hour presentations, which began Saturday, March 21 (8:30 p. m. E. S. T.), and continuing each Saturday night through April 25.

Again called "Medicine, U. S. A.," the series takes up these health topics: aging, arthritis, deafness, anesthesia, rural health, and exceptional children. Such well-known stars as Victor Moore, Helen Hayes, H. V. Kaltenborn, Kim Hunter and Robert Preston are scheduled on the programs.

Although many N. B. C. stations already have scheduled these programs, state and county medical societies are urged to check with local N. B. C. station managers to make sure the network coverage is as broad as possible. If the local station already has a program scheduled at the time "Medicine, U. S. A." is broadcast, local societies should suggest that the A. M. A. public service show be recorded off the network for rebroadcast at a later time.

A new periodical, *The Journal of Histochemistry and Cytochemistry*, is being published by the Histochemical Society six times a year. Dr. R. D. Lillie, National Institutes of Health, Bethesda 14, Md., is editor-in-chief, and the Williams & Wilkins Company, Baltimore, Md., is the publishing firm.

Do You Know? . . .

Dr. Louis J. Karnosh, Cleveland, has been named to a five year term as a member of the Advisory Council to the Division of Mental Hygiene, Judge John H. Lamneck, director of the Ohio Department of Public Welfare, announced. Dr. Karnosh is chief of the Department of Psychiatry at the Cleveland Clinic.

* * *

Three Ohio physicians were on the program of the American College of Surgeons, Sectional Meeting, held in Atlanta, Ga., February 23-24. Dr. Robert S. Dinsmore, Cleveland, presented a paper on "Pitfalls in Biliary Surgery." Dr. Robert M. Hosler, Cleveland, spoke on "Cardiac Arrest." Dr. Frank H. Mayfield, Cincinnati, was another Ohio physician on the program.

* * *

Dr. Harry Goldblatt will return to Ohio in the fall to become chief pathologist at Mt. Sinai Hospital, Cleveland. Since 1946, he has been director of the research laboratory of the Cedars of Lebanon Hospital, Los Angeles, Calif. For 25 years before that, he was on the faculty of Western Reserve University School of Medicine as professor and as associate director of the Institute of Pathology.

* * *

Examination will be given in the near future for the position of chief medical director of the Board of Education of the City of New York. Particulars may be obtained from Arthur Klein, Board of Examiners, 110 Livingston St., Brooklyn 1, N. Y.

* * *

The new officers of the Cincinnati Otolaryngologic Society are the following: Dr. Gerson Lowenthal, president; Dr. Edward Juler, secretary-treasurer. The group holds evening meetings on the third Monday of each month except July, August, September and December.

* * *

Dr. Earle Spaulding, Temple University School of Medicine, Philadelphia, will speak before a meeting of the Central Ohio Association of Operating Room Nurses in the Deshler-Wallick Hotel, Columbus, at 8:00 p. m. on April 17. His subject will be "Bacteriological Aspects in Operating Room Techniques." Physicians and members of associated professional groups are invited.

* * *

Dr. Jonathan Forman, Editor of *The Journal*, spoke on two occasions in Altoona, Pa., on February 24. He addressed two sessions of the Central Pennsylvania Dental Society on the subjects, "Modern Concepts of DISease," and "Soil, Food and Dental Health." At a noon luncheon meeting, he addressed the Altoona Rotary Club on the topic, "The Richest Business Man in the Cemetery."

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In Memoriam . . .

William H. Ambrose, M. D., Delaplane, Va.; Eclectic Medical College, Cincinnati, 1899; aged 75; died February 6. A veteran of both World Wars, Dr. Ambrose practiced medicine for about 20 years in Greenfield before entering the Medical Corps again in 1940.

Julia March Baird, M. D., Elyria; Women's Medical College of Pennsylvania, Philadelphia, 1896; aged 88; died February 11; former member of the Ohio State Medical Association, last in 1944. Dr. Baird, up until about six years ago, resided in Youngstown, where she practiced for many years. She had been medical examiner for the Y. W. C. A. and the juvenile court. Her husband was the late Charles A. Baird, D. D. S.

John F. Beachler, Sr., M. D., Piqua; Ohio State University College of Medicine, 1913; aged 63; died March 4; member of the Ohio State Medical Association through 1950; Fellow of the American College of Surgeons; secretary-treasurer of the Miami County Medical Society, 1919-1920, and chairman of several county society committees. Dr. Beachler began practice in Piqua in 1915. He retired in 1949 because of ill health. In addition to his professional practice, he was active in a number of community affairs and was a member of several Masonic orders, the Elks Lodge and the Church of the Brethren. Surviving are two sons, one of whom is Dr. John F. Beachler, Jr., also of Piqua, and a sister.

Lee J. Chapman, M. D., Lancaster; Ohio Medical University, Columbus, 1896; aged 85; died February 14. Dr. Chapman practiced in Columbus for about 25 years, part of which time he maintained his residence in Lancaster and commuted. Early in the 1920's he lost his sight through an accident, but continued to take an active part in civic affairs. Surviving are two sons and two daughters.

Theodore S. Cobbey, M. D., Canton; Harvard Medical School, 1943; aged 34; died February 19 in the Naval hospital at Portsmouth, Va.; member of the Ohio State Medical Association. After graduating from medical school, Dr. Cobbey entered the service. He spent two years in research work at the University of Washington, Seattle; returned to Canton in 1950, and established practice. On January 1 of this year, he was recalled for active duty in the Navy in the grade of lieutenant. Surviving are his widow, three daughters, a son and his parents.

William C. Davis, M. D., Columbus; Medical College of Ohio, Cincinnati, 1896; aged 78; died March 8; member of the Ohio State Medical Association, through 1947; member of the American Academy of Ophthalmology and Oto-Laryngology; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. Dr. Davis retired in 1951 after 54 years of active practice. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. In addition to his medical practice, he was active in a number of community affairs and was affiliated with the Masonic Lodge, the Rotary Club, the Columbus Country Club, and the Methodist Church. Surviving are his widow, three sons and a sister.

George T. Ely, M. D., Columbus; Cleveland University of Medicine and Surgery, 1897; aged 82; died February 25. Dr. Ely practiced at Utica before moving to Columbus in 1918. Affiliations included memberships in the Masonic Lodge and the Methodist Church. He is survived by three daughters and a brother.

Don Carlos Gaskins, M. D., Bentonville; Eclectic Medical College, Cincinnati, 1922; aged 59; died February 24; member of the Ohio State Medical Association through 1947. Dr. Gaskins served most of his professional career at Washington C. H., where he remained until his retirement several years ago. Surviving are six brothers and a sister.

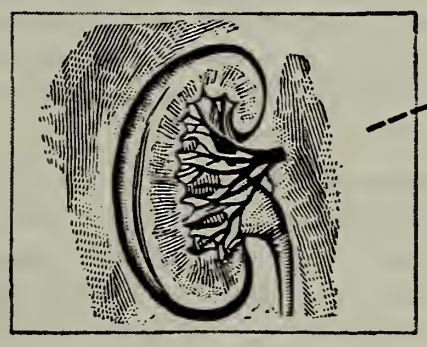
Siegfried Gurau, M. D., Columbus; medical degree from the University of Berlin Medical School; aged 84; died February 18. Dr. Gurau practiced medicine in Europe and came to this country in 1940. A son and daughter survive.

John V. Hartman, M. D., Findlay; Cleveland-Pulte Medical College, 1904; aged 75; died February 16; member of the Ohio State Medical Association; member of the American Medical Association; Fellow of the American College of Surgeons; delegate of the Hancock County Medical Society for several terms and active on County Society committees. Dr. Hartman served all of his professional career in Findlay with the exception of time served with the Army Medical Corps during World War I. In addition to his professional work, he was active in civic affairs. He was a charter member and past-president of the local Rotary Club and was a former member of the Board of Directors of the Findlay Chamber of Commerce. Other affiliations included memberships in the Country Club, the American Legion, the Elks Lodge, several Masonic orders and the Presbyterian Church. Surviving are a daughter, a brother and four sisters.

Benjamin W. Dudley Keever, M. D., Centerville, (Montgomery County); Miami Medical College, Cincinnati, 1884; aged 93; died February 17; member of the Ohio State Medical Association through 1947. Dr. Keever began his professional work in Springboro and moved to Centerville in

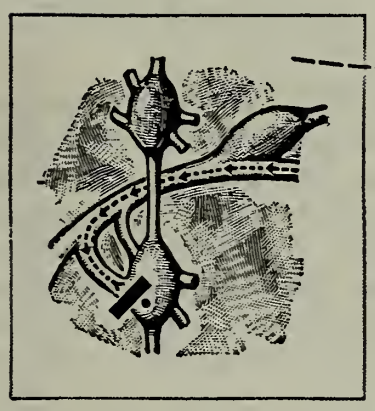
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1890. He retired in 1947 after 63 years of practice. The Montgomery County Medical Society had honored him with a life membership and by presenting him the 50-Year Pin and Certificate of the Ohio State Medical Association. Two sons survive.

Willis J. Kirkbride, M. D., Toledo; University of Wisconsin Medical School, 1938; aged 42; died March 8; member of the Ohio State Medical Association; member of the American Medical Association. A native of Toledo, Dr. Kirkbride began his practice there in 1939. During World War II, he served with the Army Medical Corps and attained the rank of major. Surviving are his widow, three sons, his mother, three sisters.

Bert D. Krug, M. D., Dayton; University of Cincinnati College of Medicine, 1941; aged 38; died February 20; member of the Ohio State Medical Association; member of the American Medical Association; member of the American Council of Chest Physicians and the American Trudeau Society. A native of Dayton, he returned there to practice after completion of his education. He took an outstanding interest in public health work, particularly in the field of cancer and tuberculosis and was the first chairman of the local Metropolitan Health Council and a member of the board of directors of the local Cancer Society. Surviving are his widow, a daughter, a son, his mother and a brother.

Andrew J. Lamb, M. D., Cleveland; Western Reserve University School of Medicine, 1935; aged 41; died February 9; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Lamb served all of his professional career in Cleveland with the exception of time in the Army Medical Corps during World War II. He was a member of the Newman Club, the Catholic Church, the Knights of Columbus and the Kiwanis Club. Surviving are his widow, a son, a daughter and his parents.

William F. Lewis, M. D., Utica; Ohio Medical University, Columbus, 1900; aged 81; died February 22; former member of the Ohio State Medical Association. Dr. Lewis started his practice in Martinsburg, but only a short time later moved to Utica where he continued in practice until his retirement in 1950. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association.

Orla W. Loffer, M. D., DeGraff; University of Illinois College of Medicine, 1897; aged 80; died February 19; member of the Ohio State Medical Association through 1950. Dr. Loffer practiced in Jackson Center and Maplewood prior to moving to DeGraff in 1905. Active in civic affairs, he had served as county auditor and on the county Republican committee. Other affiliations included memberships in the Masonic Lodge and the Methodist Church. During World War I, he served with the Army Medical Corps. Surviving are his widow, two daughters, a son, four brothers and two sisters.

Claude C. Lyon, M. D., Logan; Ohio State University College of Medicine, 1911; aged 68; died February 15; member of the Ohio State Medical Association through 1950; president of the Hocking County Medical Society, 1932, and active on several County Society committees. Dr. Lyon had practiced for many years in the vicinity, and was well known in Fairfield and Perry Counties as well as in Hocking County. His widow survives.

Edward F. McVey, M. D., Chillicothe (Veterans Hospital); Starling Medical College, Columbus, 1903; aged 70; died late in February; former member of the Ohio State Medical Association, last in 1917. Dr. McVey practiced at Clarington and at Summerfield many years ago. A veteran of World War I, he had been in the Veterans Hospital at Chillicothe for many years. Two daughters and a son survive.

Frederick Moench, M. D., Belle Center; Eclectic Medical School, Cincinnati, 1895; aged 81; died February 12. Dr. Moench practiced in Mt. Victory and Kenton before moving to Belle Center in 1936. He had been in ill health for several years. Survivors include his widow, a daughter and a son, Dr. George F. Moench, of Trenton, N. J., also a brother.

Ralph W. Reynolds, M. D., Fayette; University of Wooster, Medical Department, Cleveland, 1910; aged 64; died February 18; member of the Ohio State Medical Association; member of the American Medical Association; president of the Fulton County Medical Society, 1948-1950, its vice-president in 1931 and secretary in 1921; also a delegate for several terms and active on several local committees. Dr. Reynolds practiced for 37 years in Fayette and vicinity. Prior to that he had practiced in Stryker. A veteran of World War II, he was a member of the American Legion. Other affiliations included memberships in the Masonic Lodge and the Methodist Church. Surviving are his widow, a daughter and a son.

George J. Roberts, M. D., Westminster; Toledo Medical College, 1893; aged 88; died March 13; member of the Ohio State Medical Association through 1950. Dr. Roberts had practiced a total of 60 years, 40 of them in Allen County. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. Surviving are three daughters and two sons.

William Ferrier Waller, M. D., Sacramento, Calif.; Michigan College of Medicine and Surgery, Detroit, 1908; aged 71; died February 9; former member of the Ohio State Medical Association, last in 1917. Dr. Waller practiced in Quaker City many years ago before moving to

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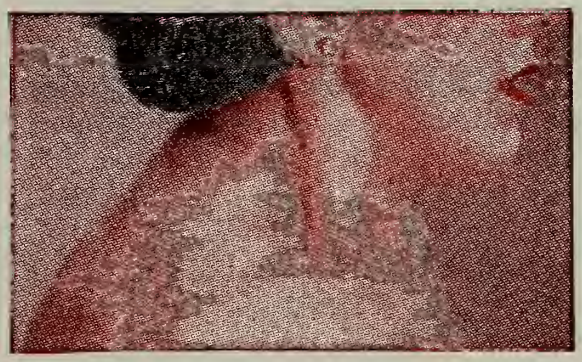
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In a review article on hormonal therapy,[1] complete relief of symptoms was reported in 62 per cent of 116 asthma patients. Another 24 per cent were made “quite comfortable.” Duration of relief varied widely, with remissions occasionally lasting as long as several months. The author calls these results “truly extraordinary.”

[1]Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* 90:96–127, July 1952.

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Angola, Ind. He moved to California about two years ago. His widow and three children survive.

Harry Osborn Whitaker, M. D., Dublin; Cleveland-Pulte Medical College, 1901; aged 77; died February 16; member of the Ohio State Medical Association and member of the American Medical Association. Dr. Whitaker practiced in South Charleston and New Burlington before World War I, during which he served with the Army Medical Corps. After the war, he moved to Dublin. He was active for many years in the Ohio National Guard and took a leading role in many community affairs, including two terms as village mayor. Affiliations included memberships in the Odd Fellows Lodge, the Masonic Lodge, and the local Community Church. Also he was a recipient of the 50-Year Pin and Certificate of the Ohio State Medical Association. Surviving are his widow, a daughter, two sisters.

Estey C. Yingling, M. D., Lima; Starling Medical College, Columbus, 1903; aged 72; died February 28; member of the Ohio State Medical Association and member of the American Medical Association; secretary of the Academy of Medicine of Lima and Allen County, 1931, its vice-president in 1931 and president the following year; delegate in 1943; also active on a number of society committees. Dr. Yingling began his practice in Beaverdam and moved to Lima in 1916. During World War I, he served with the U. S. Air Force Medical Corps. Affiliations included memberships in Sigma Chi, Theta Nu Epsilon and Alpha Kappa; the Lions Club, the Methodist Church, the Triologic Society, the Country Club and the Masonic Lodge. Surviving are a daughter and a son, Dr. Walter E. Yingling, also of Lima.

Illinois Legislature Will Investigate Krebiozen

The Illinois legislature has decided to investigate the controversial cancer drug krebiozen, which was first introduced by Dr. Andrew C. Ivy, vice-president of the University of Illinois in charge of its Chicago professional colleges. Hearings are scheduled to be held in Springfield.

As the *Chicago Daily News* said editorially:

"Krebiozen has moved over from the realm of science into the arena of politics."

Then the newspaper aptly expressed the feelings of people, generally, when it said:

"There will be hearings which cannot possibly throw any light on the value of the disputed drug, but which could perhaps build up some popular acclaim for Dr. Andrew C. Ivy as a substitute for the scientific prestige he has lost. . . . If Dr. Ivy accepts the counsel of his true friends he will transfer his subject back to the laboratory and hospital, as the only place where the ultimate truth about krebiozen can be established."

Miami Valley Hospital To Present Symposia on Polio, May 26, 27

The Miami Valley Hospital, Dayton, will present two symposia on poliomyelitis, one on Tuesday, May 26, sponsored by the Miami Valley School of Nursing and the other on Wednesday, May 27, sponsored by the Department of Physical Medicine and Rehabilitation.

The Tuesday meeting, sponsored by the School of Nursing in cooperation with the Montgomery County Chapter, American Red Cross, and the Polio Foundation, will begin at 1:30 in the hospital and will include clinical demonstrations. Moderator will be Dr. Herman J. Bearzy, director, Department of Physical Medicine and Rehabilitation.

The following program has been announced:

Nursing Procedures in the Acute, Convalescent and Chronic Stages of Poliomyelitis.

Therapeutic Applications of Hot Packs.

The Use of the Respirator and Nursing Care in the Respirator. The Advantage of the Positive Pressure Dome.

The Use of the Rocking Bed and Nursing Care on the Bed.

Physical Therapy and Occupational Therapy Procedures in the Acute, Convalescent and Chronic Stages of Poliomyelitis.

Bracing Procedures.

Color Film.

WEDNESDAY SYMPOSIUM

The Symposium on Poliomyelitis, sponsored by the Department of Physical Medicine and Rehabilitation, will be presented on Wednesday, May 27, beginning at 1:30 p. m. in the Biltmore Hotel.

A luncheon will be served at the Biltmore Hotel at 12:15 p. m., preceding the symposium. Reservations should be made with Mrs. Frances Swigart, Fidelity Bldg., Dayton, Ohio.

The following program has been announced:

Moderator: Dr. Herman J. Bearzy, director of the Department of Physical Medicine and Rehabilitation, Miami Valley Hospital.

"The Diagnosis and Treatment of Acute Bulbar and Bulbospinal Poliomyelitis," Dr. Warren E. Wheeler, professor of pediatrics, Ohio State University, Columbus.

"Physical Medicine and Rehabilitation in the Treatment of Poliomyelitis," Dr. Gordon M. Martin, Section on Physical Medicine and Rehabilitation, Mayo Clinic, Rochester, Minn.

"The Correct Psychological Attitude Toward Severe Paralytic Poliomyelitis," Dr. Kenneth D. Arn, Dayton.

"Progress in Research Pointing to the Eventual Control of Poliomyelitis," Dr. Hart E. Van Riper, medical director, The National Foundation for Infantile Paralysis, New York City.

Question and Answer period.

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Buckeye News Notes . . .

Barnesville—Work is underway on the new 30-bed hospital which contractors believe will be completed by the fall.

Canton—Dr. Alan R. Moritz, Cleveland, discussed possible connection between such diseases as cancer and heart disease with physical injuries from a medico-legal standpoint before the Stark County Bar Association.

Cincinnati—Dr. K. W. Ascher is continuing his aqueous veins research during 1953 under a Public Health Service grant recommended by the National Advisory Neurological Diseases and Blindness Council. Dr. Ascher is in the Department of Ophthalmology, University of Cincinnati College of Medicine.

Cincinnati—Judge Otis Hess addressed a joint dinner meeting of the Medical Women's Club and the Women Lawyers' Club recently.

Cincinnati—Dr. Robert C. Rothenberg spoke at the January meeting of the Cincinnati Dietetic Association on some of the newer ways in which doctors and dietitians can work together to help individuals with nutritional problems.

Cleveland—A $25,000 gift will establish a radioisotope laboratory at Mt. Sinai Hospital, according to a report in the public press. The gift was made by Dr. Alvin A. Stone in memory of his sister.

Cleveland—Dr. William S. Jordan, Jr., assistant professor of preventive medicine, Western Reserve University School of Medicine, is one of 21 physicians who received the John and Mary R. Markle Foundation grants for medical research. His research work is in infectious diseases and preventive medicine.

Columbus—Dr. John H. Mitchell addressed the Ambassador Club on the subject, "Modern Concepts in Allergic Disorders."

Columbus—Dr. Willis T. Kubiac addressed a recent meeting of the Columbus Bar Association on the subject, "Traumatic Back Injuries."

Elyria—Dr. John W. Wherry spoke on the subject, "How To Be Healthy at 40 and Over," before the local Rotary Club.

Germantown—Dr. John F. Torrence was named "Most Outstanding Citizen" by the Fraternal Order of Eagles for his outstanding service to the community. He has practiced in the area since 1921.

Jackson—Dr. Brinton J. Allison was named health-commissioner for the new unified health district comprising the entire county, and has been given the assistance of a sanitarian, two nurses and a clerk. He formerly was commissioner for rural areas of the county.

Jackson—Dr. Earl H. Stanley, physician in Jackson since 1948, announced that he had accepted the position as medical director with the Peter Kiewit Company, general contractors for the Pike County atomic energy plant. The company is scheduled to erect a medical building on the plant site and furnish auxiliary personnel. Dr. Stanley will continue his practice in Jackson on a part-time basis.

Painesville—Dr. W. H. Willis, formerly a practicing physician in the area, has been named the first full-time health commissioner of Lake County. Dr. John W. Davis formerly held the position on a part-time basis.

Solon—Dr. Chester R. Lulenski spoke on "Socialized Medicine" before the local Kiwanis Club. Dr. Edward C. Svec was in charge of the program.

Toledo—Dr. Howard E. Smith was named Toledo's outstanding young man of 1952 by the Junior Chamber of Commerce.

If you are moving to a new location or for other reason plan to change your address, please notify the Headquarters Office as early as possible so that your copy of *The Journal* and other mail may be sent to you without delay.

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Aviation Medicine Institute May Be Established at O.S.U.

Ohio State University may become the first civilian institution in the U. S. to have an Institute of Aviation Medicine.

The proposal was revealed in an announcement from Washington, D. C. Dr. W. R. Stovall, chief of the medical division of the Civil Aeronautics Administration, told newsmen if CAA plans are carried out, the Federal agency's aero-medical research center will be moved from Oklahoma City to Ohio State and greatly expanded.

The proposed move, still in the exploratory stages, would mean the establishment of an Institute of Civil Aviation Medicine devoted to teaching, research and patient care relating to aviation medicine and aeronautics. No civilian institution in the country now offers specialized training in aviation medicine, although the Air Force and Navy operate special schools in the subject at Randolph Air Force Base, Tex., and at Pensacola, Fla.

According to Dr. Charles A. Doan, dean of the College of Medicine, negotiations have been under way between the University and the CAA for several months to bring the aero-medical research center to the campus. He said the University is in favor of the move, but all arrangements have not yet been worked out. He indicated the Institute might be housed in a special unit near the University Health Center.

Name A. M. A. Delegates to World Medical Meetings

American Medical Association representatives to two important world medical meetings have been announced by the A. M. A. Board of Trustees.

Delegates, alternates and observers to the World Medical Association meeting to be held August 31 - September 4 at The Hague, the Netherlands, include: Dr. Gunnar Gundersen, LaCrosse, Wis.; Dr. E. S. Hamilton, Kankakee, Ill.; Dr. Dwight H. Murray, Napa, Calif.; and Dr. F. J. L. Blasingame, Wharton, Texas, all members of the A. M. A. Board of Trustees; also Dr. George F. Lull, secretary and general manager of the A. M. A., and Dr. Austin Smith, editor of *The Journal of the A. M. A.*

The following representatives will attend the First World Conference on Medical Education August 24-29 in London, England: Dr. Donald G. Anderson, Chicago; Dr. Herman Weiskotten, Skancateles, N. Y.; Dr. Victor Johnson, Rochester, Minn., all members of the A. M. A. Council on Medical Education and Hospitals, and Dr. Austin Smith.

Hanoverton—Dr. Henry J. Pelley, who has practiced for 60 years in the vicinity, was honored at an open house.

Toledo—Dr. Samuel D. Zuker has been named chief of the medical staff at Flower Hospital. He is in his 25th year as a staff member.

Have You an Article in this Issue?

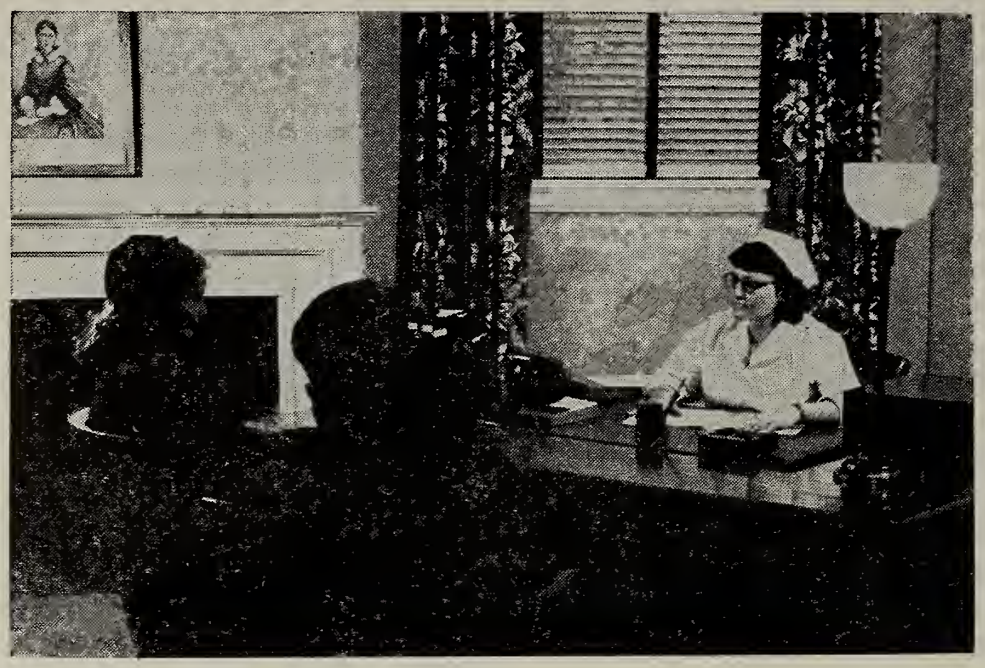
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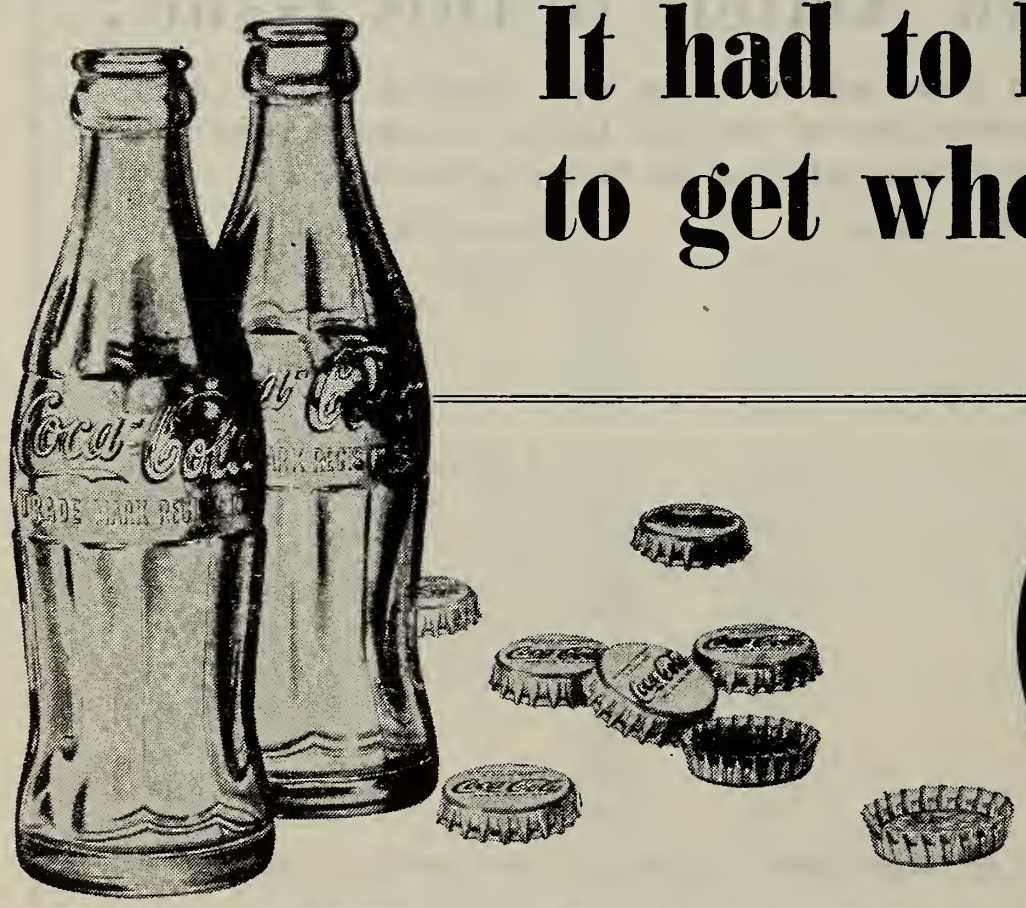
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State Mental Hygiene Aid to Local Clinics Is Limited by Opinion Of Attorney General

The State Division of Mental Hygiene has no authority to subsidize with "state funds," mental hygiene clinics operated by non-profit corporations, but does have authority to establish its own resident clinics in close association with such corporation clinics, according to a ruling by the Attorney General of Ohio.

The ruling was made at the request of Judge John H. Lamneck, director of the Ohio Department of Public Welfare, who posed certain specific questions in regard to the authority of the Division of Mental Hygiene. His questions follow:

"First, if a corporation not for profit establishes a local mental hygiene clinic to serve a specific territory, would it be lawful for the Division of Mental Hygiene under a contract with such corporation, to contribute money to such a corporation to assist in supporting such local mental hygiene clinic?

"Second, would it be lawful for the Division of Mental Hygiene to pay specific items of expense such as salaries for specified individuals who would be put on the Division's payroll to assist in operating a local mental hygiene clinic operated by a corporation not for profit?

"Third, if the Division of Mental Hygiene is authorized to expend money to assist in operating local mental hygiene clinics as outlined in questions one and two above, would it be lawful for such a corporation not for profit to charge a fee for its services to those who are able to pay, to be used to assist the corporation in paying expenses of operating the clinic?

"In connection with these questions, I desire to point out that a physician admitted to practice medicine in the State of Ohio, would be in charge of such clinic."

The syllabus of the Attorney General's opinion gives specific answers to the foregoing questions. However, in the body of the opinion, the background for the legal opinion is given.

The opinion points out that "a public body or public officer whose office is established by law, has only such powers as the General Assembly has seen fit to grant, together with such powers as are necessarily implied from the powers specifically granted. And further that, "in any action involving the expenditure of public money the law is especially strict in holding public bodies and officers to the letter of the law."

In other related fields, such as the hospitalization of the indigent sick and disabled and in child welfare, specific authority is given for appropriate action.

The restrictions apply only to "state funds," and the opinion points out that under the provisions of pertinent federal statutes and regulations of the U. S. Public Health Service, certain federal funds are granted for the purpose of direct financial aid to mental hygiene clinics

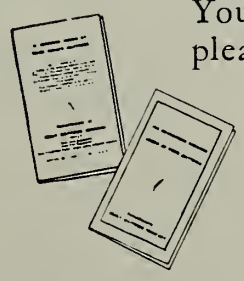


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operated by corporations not for profit. Such use of federal grant-in-aid funds is recognized by the General Assembly in the current general appropriations act.

The syllabus of Opinion 2366, given by Attorney General C. William O'Neill, follows:

"1. If a corporation not for profit establishes a local mental hygiene clinic to serve a specified territory, the Division of Mental Hygiene would have no authority under the provisions of Section 1890-9, General Code, or any other statute, to contribute money to such corporation to assist in the support of such clinic.

"2. The Division of Mental Hygiene is without authority to assign its employes to duties which involve the rendition of their services to a clinic other than one established and operated by the Division; but the Division does have authority under the provisions of Section 1890-9, General Code, to 'establish resident *** clinics *** where local clinical facilities are *** inadequate,' and any such resident clinics may be established in such close association with a clinic established by a corporation not for profit, and operated in such close cooperation with it that the two clinics will, for many practical purposes, be operated as an integrated project. In any such case, however, it will be necessary to preserve the separate entity of each clinic in matters involving control of operations and financial support."

In regard to the question about such clinics charging fees for their services, the Attorney General said that "it may be observed that some of such services will undoubtedly be of a professional nature and that they may well constitute the practice of medicine. In that regard, he referred to opinions Nos. 1717 and 1751, dated August 5, 1952, and August 20, 1952, which dealt with the corporate practice of medicine and dentistry. (These opinions were reported in the October, 1952, issue of *The Journal*, beginning on page 954.)

* * *

ATTORNEY GENERAL RULES ON DUAL OFFICE OF CORONER-SHERIFF

Following is the syllabus of Opinion No. 2178, recently given by Attorney General C. William O'Neill:

"A deputy sheriff may not serve in that capacity and also hold the office of coroner of the county."

The American College Of Allergists

The annual conclave of The American College of Allergists will be held this year at the Conrad Hilton Hotel in Chicago April 24 to April 29, inclusive.

The first four days will be devoted to instruction under the tutelage of recognized authorities and the last three to a discussion and reporting of recent advances in the field of allergy by the investigators themselves. For detailed information write The American College of Allergists, LaSalle Medical Building, Minneapolis 2, Minnesota.

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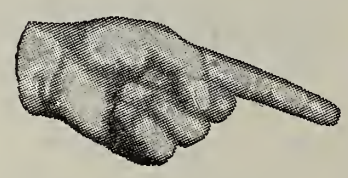
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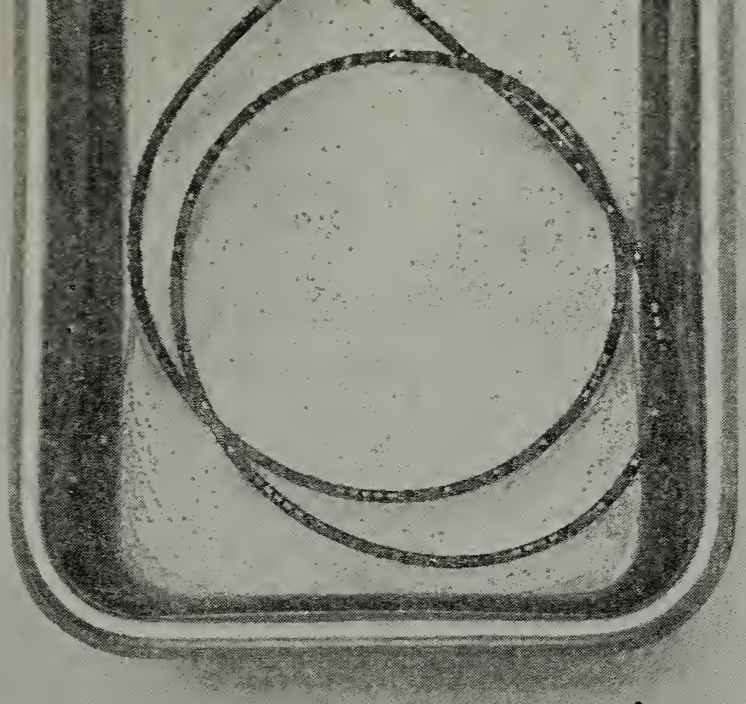


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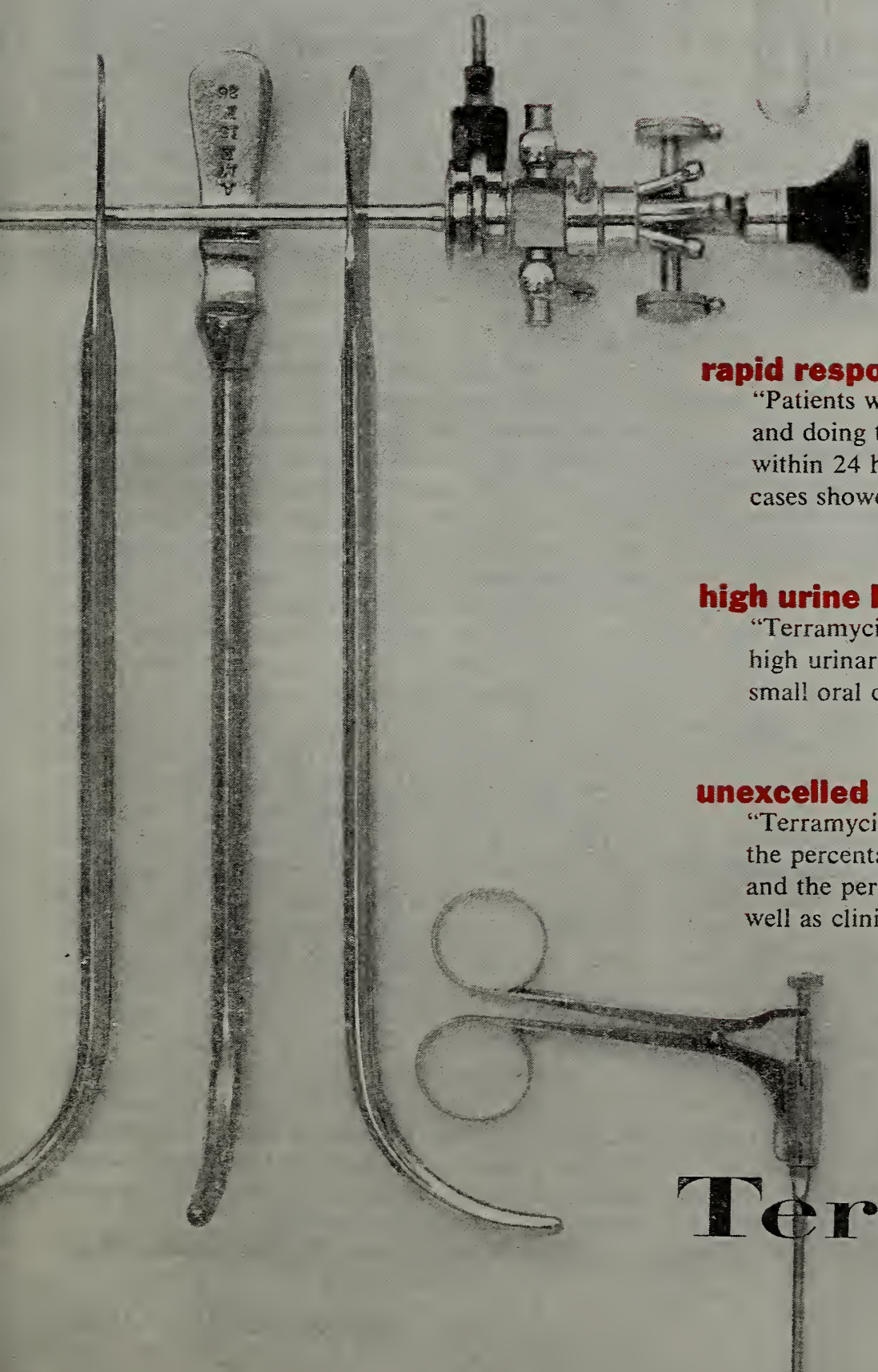


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1. Canad. M. A. J. 66:151 (Feb.) 1952.
2. J. Urol. 67:762 (May) 1952.
3. Ibid. 69:315 (Feb.) 1953.

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W. C. Rules on X-Ray Films . . .

Physicians Will Find Claims Being Processed Much More Quickly and Smoothly If They Follow Rules Laid Down by Industrial Commission

THE Industrial Commission of Ohio is still writing hundreds of letters each month to Ohio physicians in regard to x-ray films improperly filed with the Commission. When it is pointed out that on a typical day the Commission receives from 1,000 to 1,500 claims, doctors will realize that a more or less exact routine must be followed.

Improper filing results in delays, especially if additional correspondence is necessary, and the physician's fee may be held up as long as three months. During that time close to a hundred thousand claims will be handled by the Commission.

One of the principal causes of unnecessary delay is the practice followed by some physicians of filing fee bills for x-rays before the films are submitted to the Commission. The Commission cannot pay such fee bills until the films and interpretations are on file.

Also numerous x-ray films are being returned to physicians each month because of lack of claim numbers and proper identification or because they cover injuries for which no claims have been filed.

A suggested procedure for keeping track of claim numbers was reported in the February issue of *The Journal*, page 156.

George H. Thompson, supervisor of claims for the Industrial Commission, and Clark C. Grubbs, assistant supervisor of claims, have been holding conferences throughout the State with physicians, nurses, physicians' secretaries, x-ray technicians and others who handle claims to discuss procedures. Physicians are invited at any time to send their secretaries to the Columbus Office of the Industrial Commission where they will be given instruction on procedures and in filling out proper forms.

SUGGESTED PROCEDURE

Adjudication of claims and payment of fee bills for x-ray examinations will be expedited if the following suggestions of the Claims Section are followed:

A. **No fee bills for x-ray should be filed until the claim number has been secured from either the employer or the Industrial Commission.** Employers are notified of the claim number as soon as a claim is filed and processed by the Commission, and are instructed to make the information available to all physicians rendering services to the claimant.

B. When a claim number has been secured, **the films, fee bill and interpretation should be sent direct to the Commission.** It is most important that the fee bill be forwarded in the **same enclosure** with the films and interpretation.

C. **Films should never be attached to a C-3 (Medical-Only) claim.** When a claim is for a fracture, which results in no lost-time for the injured workman, the C-3 form should be used only to establish the claim and to obtain payment of the fees for treatment, not the fee for x-ray examination.

The attending physician should note on Part III of the C-3 that fee bill and x-ray films will be filed upon receipt of a claim number. When the Industrial Commission receives the C-3, a fee bill containing the claim number, claimant's name, date of injury and name of employer will be sent to the attending physician, if he made the x-ray examination himself. If the x-ray examination is made by a physician other than the attending physician, his name and address should appear on Part III of the C-3, and he will receive proper forms from the Commission for submitting his bill along with films and interpretation.

RULES ON X-RAY

Following are the "Rules on X-Ray," as published in the Bulletin of the Industrial Commission containing general information, rules of procedure and fee schedules for the information of physicians, dentists, nurses and hospitals:

1. **Necessity for Examination Must Be Apparent.** An x-ray examination may be made in any case where it is clearly shown that such an examination is essential in the diagnosis or treatment of an industrial case.

2. **To Whom Payments Are Approved.** The payment of fees for x-ray examinations is made only to licensed physicians and dentists, and to the latter only for examinations of the teeth, mandible and maxilla. No fees are approved for x-ray examinations by limited practitioners.

3. **Films and Interpretation Must Be Submitted.** The films and interpretations signed by the physician making the examination must be on file before fees for x-ray examinations are approved. Prints, reductions or duplicate films, when legible and diagnostic, may be substituted for the original films. The original films however, must be submitted in claims filed for silicosis and other respiratory diseases.

4. **Manner in Which Films Should Be Marked.** Films and prints must be plainly marked in white ink, giving the number of the claim, name of the claimant, date of injury, date of examination, name of employer and name of the physician making the examination.

5. **How Films Should Be Submitted.** Films,

signed interpretation and fee bill must be submitted together. The films must be mailed flat. Use of a standard x-ray envelope which has a container pocket on the outside for the interpretation and fee bill is suggested.

6. **Rejection of Films When Not Diagnostic.** The Commission reserves the right to refuse to pay for an x-ray examination in which the films are not diagnostic or the examinations do not conform to the rules on x-ray.

7. **Films Must Be Correctly Processed.** Films to be accepted must be correctly processed as well as diagnostic as they become legal documents and must remain legible for a period of ten years.

8. **Views Required.** Both antero-posterior and lateral (or oblique) views must be submitted for all parts of the body, with the exception of the shoulder and hip joints, pelvis and lungs, in which examinations the antero-posterior view only is required. When only one view is submitted for those parts for which two views are required, one-half of the established fee is paid. Not less than three views in different directions are to be submitted in examination of the skull.

9. **Parts of Body Considered as Separate Parts.** In approving fee bills, cervical, dorsal, lumbar and sacro-coccygeal areas of the spine are considered as separate parts. The entire pelvis and upper thirds of the femora (if they are included on the film) are considered as one part. The entire chest is considered as one part.

10. **Stereoscopic Examinations.** Stereoscopic examinations may be made when unquestionably indicated or when authorized by the Commission. The Commission reserves the right of decision on the indication for stereoscopic examinations in the individual claim. Authorization is not required for stereoscopic examinations in Silicosis claims. The fee for such examination is the established fee and an additional fifty per cent.

11. **Fees for Fluoroscopy.** No fees for fluoroscopy will be approved except for its use in removal of a foreign body.

12. **X-ray Therapy.** No fee will be approved for superficial or deep x-ray therapy unless such treatment is administered by a recognized roentgenologist or a dermatologist. (A recognized roentgenologist or dermatologist is interpreted as one who limits his practice to the use of x-ray or to treatment of diseases of the skin, whichever the case may be.)

Fees for superficial x-ray therapy will not be approved for more than five treatments unless authorized. The nature of the disease must clearly indicate the necessity for such treatment.

Fees for deep x-ray therapy must be authorized in advance.

Fee bills for x-ray therapy given in hospitals

(Continued on Page 366)

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DOSAGE Total daily dose of 0.8 to 2 Gm., depending on severity of the infection. A total daily dose of 0.6 Gm. is often adequate in the treatment of pneumococcic pneumonia. *For the average adult* the initial dose is 0.2 Gm. to be followed by doses of 0.1 or 0.2 Gm. followed by doses in the same range every four to six hours. *For severely ill patients* doses up to 0.5 Gm. may be repeated at six-hour intervals if necessary. Satisfactory clinical response should appear in 24 to 48 hours if the causative organism is susceptible to ERYTHROCIN. Continue for 48 hours after temperature returns to normal.

Abbott

1. McGuire et al. (1952), J. Antibiotics & Chemo., 2:281, June.
2. Heilman et al. (1952), Proc. Staff Meet. Mayo Clin., 27:385, July 16.
3. Haight and Finland (1952), New Eng. J. Med., 247:227, Aug. 14.

must be filed over the signature of the radiologist giving the treatment.

Physicians rendering any type of medical service to claimants covered by the Workmen's Compensation Act should remember that fee bills must be filed within two years from the time such services were rendered or within six months from the time the Commission has assumed jurisdiction in a contested or reopened claim. The Industrial Commission is prohibited by law from paying bills filed after the foregoing time limitations have expired.

Toledo Academy Reinstates Two

On March 13, the Council of the Toledo Academy of Medicine rescinded its action of January 20, expelling from membership Dr. Stephen Donath and Dr. Louis R. Effler and referred their cases to the Professional Relations Committee of the Academy for consideration. The action was taken because they had not been given an opportunity to be heard or to present witnesses relative to court action on charges that they had violated the Federal narcotics law.

Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D. CINCINNATI)

CLINTON

Dr. Philip Hardeman, Columbus, spoke on the subject, "Thoracic Injuries" at the March 3 meeting of the Clinton County Medical Society in Wilmington.

HAMILTON

The Academy of Medicine of Cincinnati has announced the following features for its programs in April and May in the College of Medicine Auditorium:

April 7—"Insulins in the Management of Diabetes Mellitus," (Joint meeting with the Council on Diabetes), Dr. F. B. Peck, associate professor of medicine, Indiana University School of Medicine.

April 21—"Surgical Management of Inflammatory Lesions of the Large and Small Intestines," Dr. Henry Cave, clinical professor of surgery, Columbia University College of Physicians and Surgeons.

May 5—"Cutaneous Manifestations of Systemic Disease," Arthur C. Curtis, professor of dermatology and Syphilology, University of Michigan Medical School.

May 19—"Personal Experiences in Cardiology," Dr. Paul White, clinical professor of medicine, Harvard University Medical School.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

A panel discussion on the subject, "Rheumatoid Arthritis and Osteoarthritis," was held at the March 16 meeting of the Clark County Medical Society in Springfield.

DARKE

"Surgical Aspects of Congenital Heart Disease" was the subject discussed by Dr. Charles O'Brien, Dayton, before the Darke County Medical Society meeting on March 17 in Greenville.

MIAMI

Dr. Lewis Owens, associate professor of medicine, University of Cincinnati College of Medicine, spoke on the subject, "Common Problems of Diabetes in General Practice," at the February 6 meeting of the Miami County Medical Society. The dinner meeting was held at the Stouder Hospital, Troy.

Dr. George T. Harding, Worthington, presented a discussion on "The Problems of Psychiatry in General Practice," at the March 6 meeting of the Society in Piqua.

MONTGOMERY

Dr. Howard C. Taylor, Jr., professor of obstetrics and gynecology, Columbia University, spoke on the topic, "Diagnosis and Treatment of Ovarian Tumors," at the March 20 meeting of the Montgomery County Medical Society at the Miami Valley Hospital Memorial Nurses' Home. It was a combined meeting with the Miami Valley Hospital staff, the staff of the St. Elizabeth Hospital and the Dayton Obstetrical and Gynecological Society.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

CRAWFORD

Dr. Lloy D. Bonar, of Mansfield, addressed the Crawford County Medical Society at Bucyrus on March 20. His subject was "Endocrinology of the Female." Dr. J. R. Jarvis, Van Wert, Councilor of the Third District, was a guest visitor.

HARDIN

Dr. L. N. Irvin, Lima, addressed the Hardin County Medical Society at its March 10 meeting. His subject was "The Heart and Psychodynamics of Edema."

MERCER

Dr. J. R. Jarvis, Van Wert, Councilor of the Third District of the Ohio State Medical Association, addressed the Mercer County Medical

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Society at its March 12 meeting on "The County Medical Society and Its Public Relationship."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

Guest speaker at the March 3 meeting of the Summit County Medical Society in Akron was Dr. O. Erik Hallberg, consultant in the Department of Otolaryngology and Rhinology, Mayo Clinic, and assistant professor in the Mayo Foundation Graduate School, University of Minnesota. He spoke on the subject, "Severe Nose Bleed and Its Treatment."

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

TUSCARAWAS

Twenty-six members attended the February 12 meeting of the Tuscarawas County Medical Society. A number of dentists from the county and lay guests also were present.

The president, Dr. Benjamin Pilloff, presided. Speaker of the evening was Dr. Raymond Rosedale, Canton, who spoke on "Common Diseases of the Head and Neck." He illustrated his talk with self-made photographs in natural colors.

Dr. Pilloff reported that he had met with Dr. Kirk, area physician for the Red Cross blood collection program. It was announced that if a walking blood donor list for each hospital is presented to those in charge at the bloodmobile, these donors will be screened and will not be accepted for blood donation.

Dr. R. J. Foster, chairman of the Public Relations Committee, requested that members send him their appraisal and criticisms of the present medical program for the Aid for the Aged and County Relief participants.

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

ATHENS

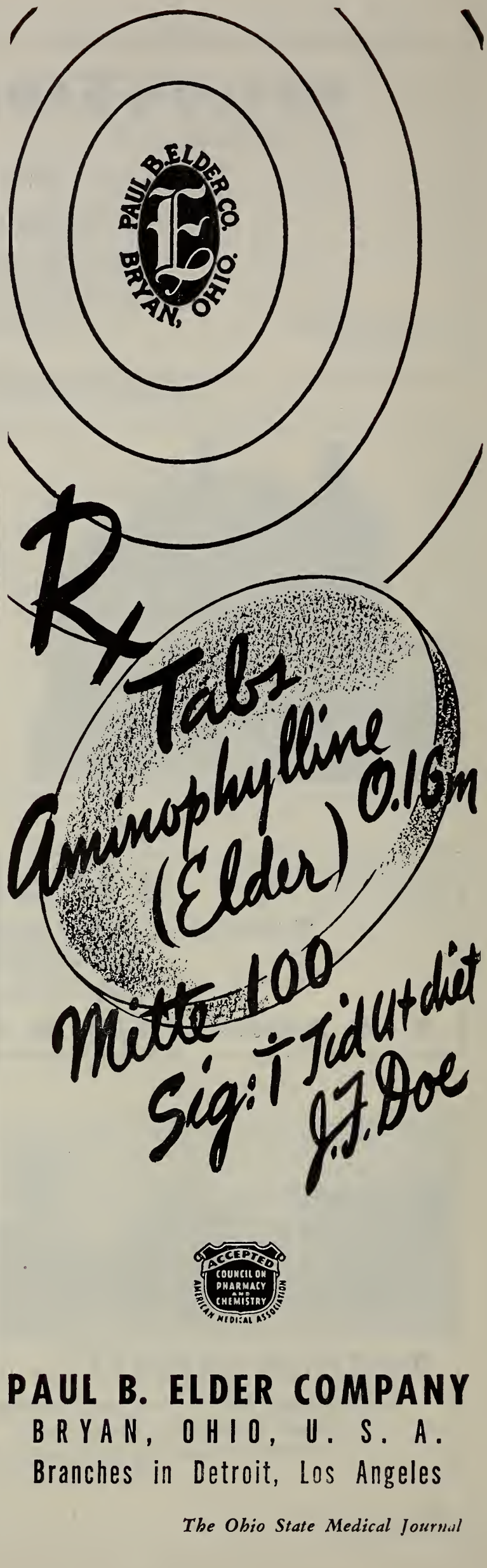
Physicians of Washington and Athens Counties and Parkersburg met at the Athens Country Club on March 12 for dinner and a scientific program. Guest speaker for the occasion was Dr. Joseph E. Moore, professor of Medicine at Johns Hopkins University School of Medicine, Baltimore, who spoke on the subject, "The Importance of Collagen Diseases."

Ninth District

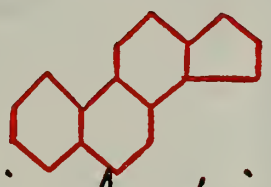
(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

SCIOTO

At the February 9 meeting of the Scioto County Medical Society in Portsmouth, two physicians



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SCHERING

from the Division of Gastroenterology, Ohio State University College of Medicine, presented the scientific program. Dr. Floyd M. Beman spoke on "Abdominal Pain," and Dr. C. Joseph DeLor discussed "Office Management of Common Gastrointestinal Problems."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

"Surgery of the Heart, with Special Emphasis on Coronary Artery Disease," was the subject of a talk by Dr. Claude S. Beck, professor of cardiovascular surgery, Western Reserve University School of Medicine, at the February 10 meeting of the Lorain County Medical Society.

At the March 10 meeting of the Society, Dr. Robert Hosler, Cleveland, spoke on the subject, "Cardiac Resuscitation."

Woman's Auxiliary . . .

By MRS. JAMES E. MULLEN, Chairman, Publicity Committee, 572 E. Front Street, Perrysburg

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ALLEN

The Woman's Auxiliary to the Lima and Allen County Academy of Medicine sponsored its annual benefit card party on Feb. 24 in the McAuley hall of St. Rita's Hospital. Proceeds will be used to purchase equipment for the new Northwest Guidance Center and for the Auxiliary's nurse loan scholarship fund. Arrangements were made by the hospitality committee, under the chairmanship of Mrs. Charles L. Blumstein and Mrs. H. C. Kingsbery.

AUGLAIZE

Auglaize County Auxiliary met on Feb. 18 at the home of Mrs. Herbert Wolfe. During the business meeting, plans were made for participation in the nurse recruitment program. A letter of thanks was received from the secretary of the Eastern Auglaize County Chapter of the American Red Cross for the Auxiliary's efforts in the blood recruitment program. The Auxiliary voted to contribute $5.00 to the State Nurses' Loan Fund. After the business meeting, the members made two scrapbooks, one for the pediatrics ward of each hospital in Lima.

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were shown at a meeting of the Wapakoneta Woman's Club on Feb. 24. "Meats with Approval" dealt with the meat plant inspections, and "Feeling of Hostility" demonstrated the necessary factors for the development of a sense of security in children.

BUTLER

"Why I Should Like to be a Nurse" is the topic of an essay contest being sponsored by the Woman's Auxiliary to the Butler County Medical Society. Awards of $15, $10 and $5 will be given in tribute to the memory of Esther M. Brossius. Participants in the essay contest are invited to a tea, as guests of the Auxiliary, on March 24 at the Ft. Hamilton Hospital Nurses Home.

A luncheon meeting was held at The Colony on Feb. 24. Plans were discussed for the annual Horse Show which is the group's major project for the purpose of raising funds for patients in Hughes Memorial Hospital. Mrs. William Porter gave a review of Mary Bard's humorous "Forty Odd."

CHAMPAIGN

Champaign County Auxiliary met for luncheon in Millner's Colonial room on March 2. Mrs. F. R. Grogan, president, conducted the meeting, at which a report was given on the survey conducted by the Auxiliary to determine the need for *Today's Health.* The group voted to assist the hospitals in preparation of Hospital Day on March 12. The following members were appointed to the nominating committee: Mrs. A. B. Ream, chairman, Mrs. M. C. Houston and Mrs. David H. Moore. The next bloodmobile visit to Urbana was announced for March 13.

CUYAHOGA

Members of the Woman's Auxiliary to the Cleveland Academy of Medicine met for luncheon in February at the Visiting Nurse Association Building. Mrs. Charles S. Higley presided at the meeting. Recognition for personal achievement was given to eleven student nurses from the city's two collegiate and nine hospital schools of nursing. Each girl was presented a check for $25.00 by Mrs. Abram B. Bruner.

Luncheon speakers included Mrs. David K. Ford, president of the Council on Community Nursing; and Warren Guthrie, professor at Western Reserve University, whose topic was "Making Phrases at Each Other."

ERIE

The annual guest day luncheon of Erie County Auxiliary was held at the Business Women's Club on March 2. Mrs. William C. Seiler was chairman of arrangements, assisted by Mrs. F. O. Fry, Mrs. D. E. Sheldon and Mrs. Russell Taylor. Mrs. A. G. Groscost presided at the short business meeting which followed the luncheon. Guest speaker was G. J. Gray, Toledo agent

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of the Bureau of Narcotics of the U. S. Treasury Department, who related many interesting statistics concerning narcotics, and the law enforcement procedures concerned with the traffic of narcotics and with the treatment of addicts.

FAIRFIELD

At the February meeting of the Fairfield County Auxiliary held at the home of Mrs. William D. Monger, plans for the annual Nurse Recruitment Tea to be held March 23 were made. Mrs. Fred E. Spangler was named general chairman. Mrs. Wilford D. Nusbaum gave a report on the recent party at the County Home, and other committee reports were presented. Mrs. G. S. Rodabaugh, associate member of Branford, Conn., was a guest.

FRANKLIN

New officers were elected at the Feb. 15 meeting of the Woman's Auxiliary to the Columbus Academy of Medicine held at the Columbus Gallery of Fine Arts. To be installed at the spring luncheon on May 18 at the Ohio Union are the following: Mrs. Harve M. Clodfelter, president; Mrs. Henry B. Lacey, president-elect; Mrs. John M. Lowery, vice-president; Mrs. A. L. Kefauver, treasurer; Mrs. Martin Peter Sayers, recording secretary; and Mrs. Philip Hardymon, corresponding secretary.

Mrs. Robert H. Schoene, president, announced contributions made during the year as follows: $100 to the Bureau of Juvenile Research; $100 to the Cerebral Palsy Clinic; $300 to Alum Crest Hospital; $300 to the American Medical Education Foundation, and $500 to the nurse scholarship fund.

Mrs. Edward Klopfer introduced the speaker, Rabbi Jerome D. Folkman who spoke on "The Gentle Art of Being a Wife." Tea was served in the gallery's Session Room, with Mrs. Alexander Pollack as chairman.

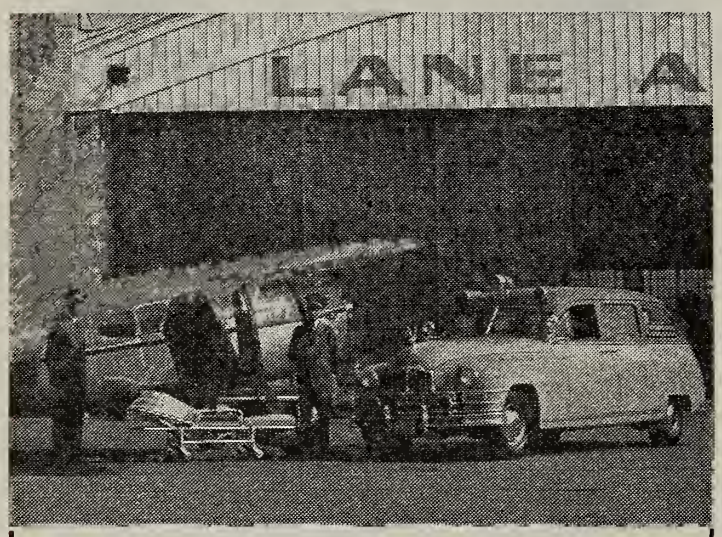
GREENE

Mrs. L. W. Sontag, president of Greene County Auxiliary, conducted a Board meeting in her home on Feb. 27. Mrs. Robert D. Hendrickson, whose husband has been called to active duty with the Air Force, submitted her resignation as president-elect and Mrs. Richard F. Kelly was named as her successor. Mrs. Harold E. Ray, chairman of the nurse recruitment committee, discussed plans for a social event at which prospective nurses, who are applicants for the Auxiliary's annual scholarship, will be feted.

The Auxiliary's annual public relations meeting, open to all interested persons, was held in Central High School Auditorium on March 10. Jarvis Couillard, a film writer and director of documentary films, spoke on "Availability of Documentary Films." He explained how to obtain and show these films for organizational and educational purposes. Two films on public health, "So Much For So Little" and "How to Catch a Cold," were shown, in addition to two on mental health, "Angry Boy" and "Toy Maker." Mr. Couillard also screened a film, "Little Schoolhouse in the Red," depicting economic problems of small rural schools.

HAMILTON

Hamilton County Auxiliary met for luncheon on Feb. 17 at the Hotel Sinton. At the business meeting conducted by Mrs. William H. Lippert, the report of the nominating committee was presented. Mrs. Herbert J. Brinker, program chairman, introduced Dr. Robert A. Kehoe, di-



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rector of the Kettering Laboratory of the University of Cincinnati, who spoke on "Lead Poisoning in Children." Special guests at the meeting were the advisors from the Cincinnati Academy of Medicine—Dr. Daniel E. Earley, Dr. Dale P. Osborn and Dr. Cecil Striker.

HURON

Huron County Auxiliary met at the home of Mrs. T. H. Smith on Feb. 13. It was decided to notify all Huron County high schools of the availability of the nurses' loan fund. Mrs. F. B. Western presented a program on "Today's Health." Following the meeting, the hostess showed colored slides of Mexico.

KNOX

Mrs. John Chalmers of Gambier told of her year in the Philippines at the Feb. 25 meeting of Knox County Auxiliary held at the home of Mrs. J. W. Allman of Centerburg. Ten members volunteered for work with the Ground Observers Corps in Mount Vernon and one for the Centerburg Corps.

LICKING

Licking County Auxiliary held a dinner meeting at the Hotel Warden on February 25. Reports were read by the officers, followed by Mrs. W. C. Myers' review of *Forty Odd* by Mary Bard.

LUCAS

A luncheon meeting of Lucas County Auxiliary was held at the Academy Building on Feb. 17. Mrs. W. R. Gibson, Fourth District Director, was a special guest. Mrs. Boni Petcoff introduced Dr. Asa Knowles, president of the University of Toledo, who spoke on "Health and Education."

The Live Issues of Today (afternoon group) met at the home of Mrs. Emidio L. Gaspari on March 4. The evening group met on March 6 at the home of Mrs. David L. Friedman. The subject of both meetings was "What To Do About Africa?"

Mrs. Myron Means conducted a Board meeting on March 4 at the Academy Building.

MAHONING

About 250 members and guests enjoyed the spring style show which the Mahoning County Auxiliary presented Feb. 18 at the Rodef Sholom Temple. The fashion parade followed a dessert luncheon served cafe style. Also featured were gay nineties costumes introduced by Mrs. E. E. Kirkwood, co-chairman with Mrs. Harold Chevlen. Comedy dancers and appropriate music were added attractions.

MARION

Marion County Auxiliary entertained a group of high school girls at a nurse recruitment tea in February in the community room of the West Town Bank. Mrs. M. M. Weinbaum, president, welcomed the guests. Mrs. T. H. Herbert, head

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POSTGRADUATE COURSES—1953

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GYNECOLOGY—Intensive Course, two weeks, starting April 20. Vaginal Approach to Pelvic Surgery, one week, starting May 4.

OBSTETRICS—Intensive Course, two weeks, starting June 8.

PEDIATRICS—Congenital Heart Disease, two weeks, starting May 18. Cerebral Palsy, two weeks, starting June 15.

MEDICINE—Intensive General Course, two weeks, starting May 4. Electrocardiography & Heart Disease, two weeks, starting July 13. Allergy, one month and six months by appointment.

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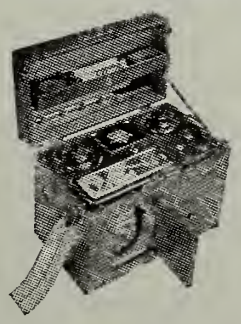
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of nurse recruitment at Toledo Hospital, was the guest speaker. She was accompanied by two student nurses. Mrs. Herbert talked on nursing as a profession and showed pictures of various phases of hospital work and training. The student nurses discussed training, recreation and other activities planned for the students.

Members of the social committee were in charge of the tea, and Mrs. J. G. McNamara presided at the tea table.

MONTGOMERY

One hundred eighty-seven members of Montgomery County Auxiliary met for luncheon at Rike's Dining Room on Feb. 17. During the business session, election of officers for 1953-54 was held. Mrs. Alta Becker reviewed a current book.

OTTAWA

Members of the Ottawa County Auxiliary met at the home of Mrs. Jack Witker, Lakeside, on Feb. 20. A St. Patrick's Day treat for residents of the County Home was planned, and Mrs. W. P. Shortridge offered to provide hospital tray favors on that day. Following the business meeting, Mrs. Witker presented a program on civil defense.

RICHLAND

Dr. Paul Dozier explained the functions of the Mansfield Guidance Center to members of the Richland County Auxiliary at a luncheon meeting on March 2 at the Women's Club. Hostesses for the meeting were Mrs. Myron S. Reed, Mrs. Robert P. Scott and Mrs. Russell H. Barnes.

Auxiliary members entertained members of the Medical Society at a dinner party at Westbrook Country Club on March 20. Mrs. Milton Oakes was chairman of the committee on arrangements.

SANDUSKY

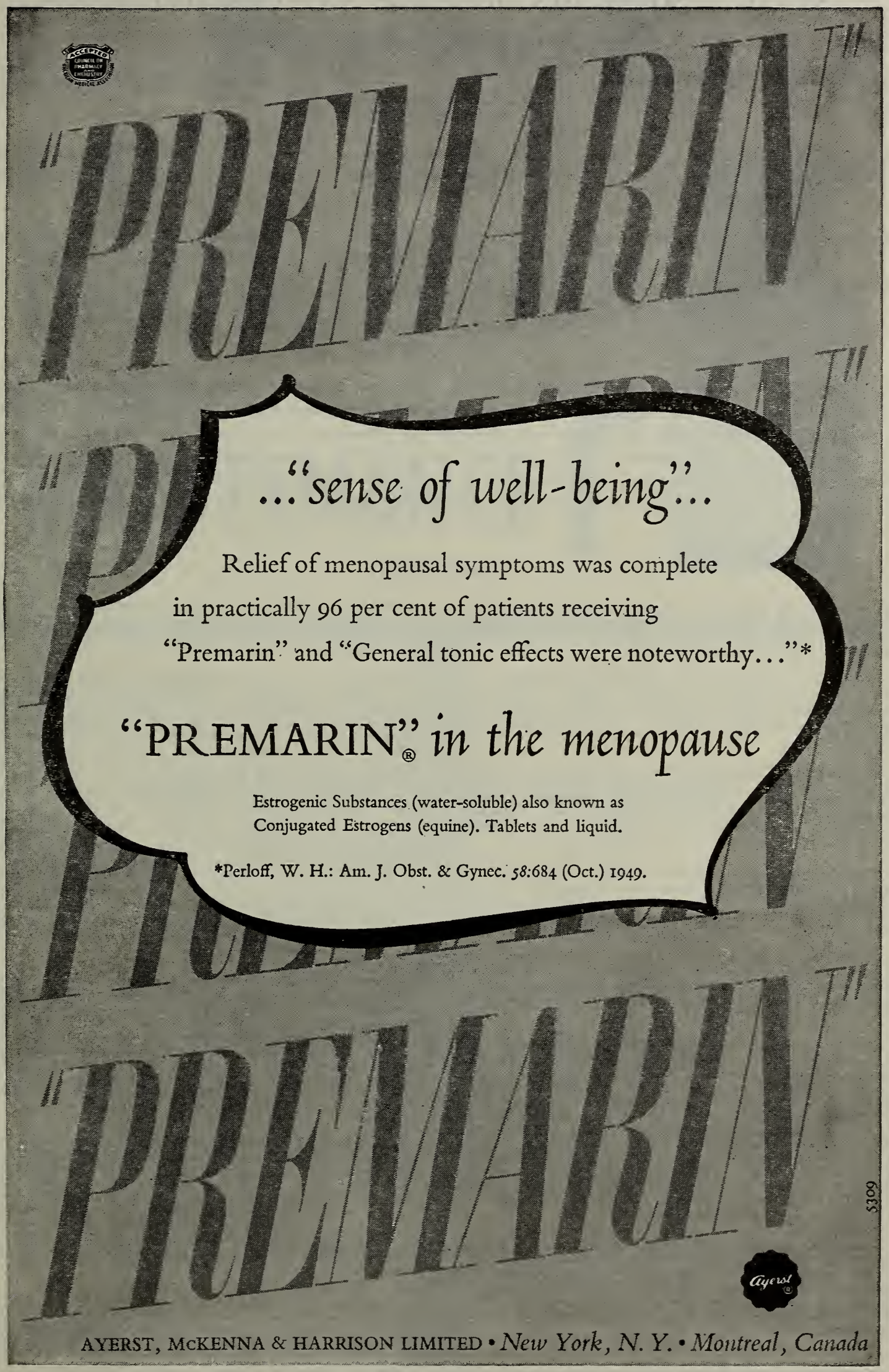
Mrs. C. G. Egger was hostess to members of Sandusky County Auxiliary on Jan. 27. Guest speaker was R. J. Geary who talked on the history of life insurance.

The Feb. 24 meeting was held at the home of Mrs. W. H. Booth. The program was a panel discussion of current events and new developments in medicine. Mrs. J. L. Curtin spoke on "Good Health Is Your Most Precious Possession." Mrs. F. A. Visconti's topics were "Availability of Gamma globulin for Inoculation Against Poliomyelitis" and "Public Health Rules for Communicable Diseases." Mrs. A. F. Shultz discussed an article entitled "It Is Not Good to Blow Your Top." Mrs. E. L. Koons reviewed a story on "The Blockade of China." Mrs. H. L. Keiser contributed to the program with a talk on "Unity, Our Hope for a Free World."

(Editor's Note: Additional Auxiliary County Society notes, submitted for this issue are omitted because of lack of space. They will be published in the next issue.)

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.
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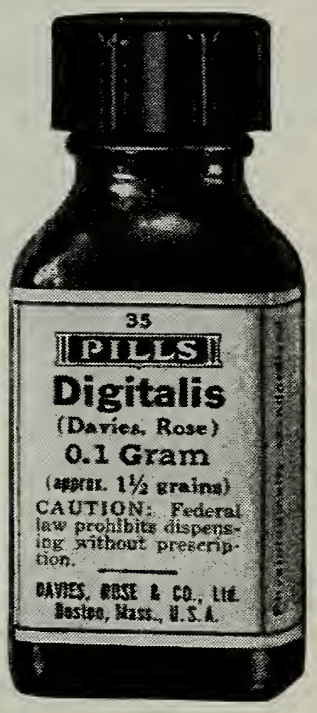
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BUTLER—Willis F. Hume, President, Hamilton; Hazelett A. Moore, Secretary, Oxford. 4th Wednesday, monthly.

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CLINTON—James H. Frame, President, Wilmington; Robert E. Suer, Secretary, Wilmington. 1st Tuesday, monthly.

HAMILTON—Daniel E. Earley, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 371 Doctors Bldg., Cincinnati. 2nd and 4th Tuesday, monthly, except June, July and Aug.

HIGHLAND—Joshua B. Glenn, President, Greenfield; George L. Morris, Secretary, Hillsboro. 1st Wednesday, monthly.

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lotte Ames, Secretary, Xenia. 2nd Thursday, monthly.

MIAMI—Hugh Wellmeier, President, Piqua; G. A. Woodhouse, Secretary, Pleasant Hill. 1st Friday, monthly, except Aug. and Sept.

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WILLIAMS—Victor L. Boerger, Secretary, Edgerton. Last Tues., monthly.

WOOD—F. F. Price, President, Stony Ridge; Donald L. Gamble, Secretary, Bowling Green. 3rd Thurs., monthly.

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FAIRFIELD—William S. Jasper, President, Pleasantville; A. B. Van Gundy, Secretary, Lancaster. 2nd Tuesday.

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SCIOTO—Sol Asch, President, Portsmouth; Joseph T. Gohmann, Secretary, Portsmouth. 2nd Monday, monthly.

VINTON—R. E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur. No regular meeting date.

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FRANKLIN—Robert C. Kirk, President, Columbus; Mr. Stanley R. Mauck, Executive Secretary, 79 E. State St., Columbus. 3rd Monday.

KNOX—Joseph W. Allman, President, Centerburg; James C. McLarnan, Secretary, Mt. Vernon. No regular meeting date.

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MORROW—Stanley L. Brody, President, Cardington; David James Hickson, Secretary, Mt. Gilead. 4th Tuesday.

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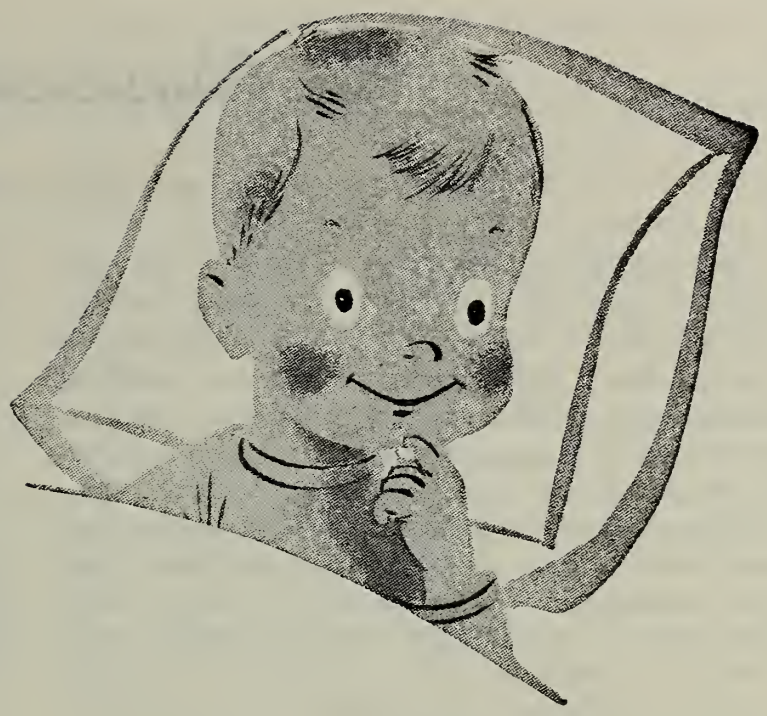
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MEDINA—Herbert F. Cowgill, President, Wadsworth; Otis G. Austin, Secretary, Medina. 3rd Thursday, monthly.

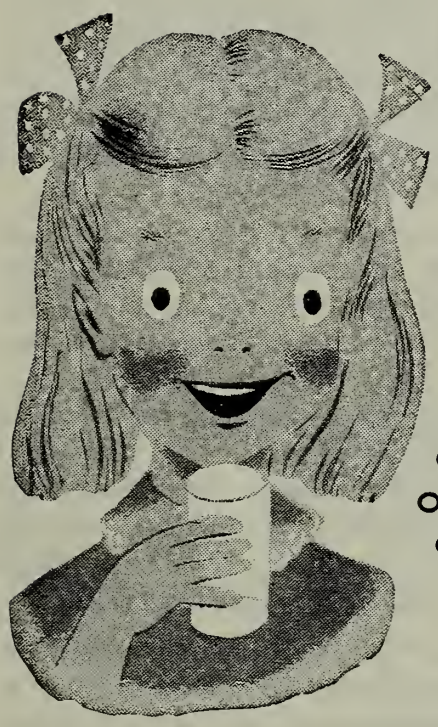
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Are These Our Doctors? by Evelyn Barkins, ($2.50. *Frederick Fell, Inc., New York 16, N. Y.).* In this book a doctor's wife, the author of **The Doctor Has a Baby,** writes an intimate, revealing book about doctors and their patients. The author herself is a practicing attorney and in this work has drawn up a general indictment of her husband's profession based, unfortunately, upon the conduct of a few disreputables who infest the medical profession as they do every other. The result is a juicy 190 pages of gossip which draw a sensational but very distorted picture of modern medicine—very unfair to the majority of hard working physicians. A sordid tale of disagreements among doctors, the lack of medical ethics, and the rise of specialists who overcharge; of indifference and ignorance of the long time effects of our modern drugs; of medical fads provided by hucksters in popular magazines.

We are certain that the author with her legal training can furnish living examples of every point in her indictment but your reviewer is absolutely certain it is the indictment of a small minority of his profession.

On the other hand, her statement that we physicians are oversold to the public has a great deal of merit as does her complaint about our professional demeanor—a remnant of days when it was our greatest stock in trade. Then too, she makes a good case for the general practitioner and explains in clear language how every citizen should put his sickness needs in the hands of one such medical man, and when visiting a specialist she wisely advises that the first question should be, "How much is this going to cost me?"—a bit of advice that your reviewer has been broadcasting for years. The amount of proposed fee is not, necessarily, a measure of the physician's knowledge and skill.

Finally, our modern method of experimentation, clinical trial, exploration and at long last, proper evaluation of one new drug after another comes in for ridicule and condemnation. There is no doubt that this makes medication terribly expensive. A pharmaceutical house invests 5 millions in a plant to produce a serum against pneumonia only to have the serum treatment junked for the sulfa compounds; the manufacturers of sulfa then meets almost the same fate from the antibiotics. It is expensive—(Every patient of your reviewer spends more for drugs than he pays his physician). At the same time, it makes for extremely rapid progress. Who can compute the value of the thousands of lives which have thus been saved to set over against this enormous drug bill? There however is enough truth in this author's criticism to make us stop and take stock of ourselves and of our friends, the nurses and the drugs.

A 40 Year Campaign Against Tuberculosis, by Louis I. Dublin, Ph. D.,—A Record of the Contributions of The Metropolitan Life Insurance Company. *(Metropolitan Life Insurance Company, New York, N. Y.).* Few of us realize on what a variety of fronts this company has so greatly helped all who have been engaged in this campaign. The current death rate from tuberculosis represents a decline of about 90 per cent in the past 40 years. Still the disease is a serious medical problem.

Injury of the Xiphoid, by Michael Burman, M. D., and Samuel E. Sinberg, M. D., ($3.50. *Columbia University Press, New York 27, N. Y.),* should interest the general surgeon, the orthopedic surgeon, the chest surgeon, the internist, the roentgenologist, and the surgeon dealing with trauma as well as all concerned with legal and compensation cases. The modern automobile has focused our attention on this subject for the first time since the Middle Ages. This monograph is based upon the author's personal experiences.

A Doctor Looks at Life, by Witten Booth Russ, M. D., ($3.00. *The Naylor Co., San Antonio 6, Texas),* is the autobiography of one of the outstanding citizens of Texas, one of the nation's foremost surgeons and a leader of American Medicine. The author gives us his reaction to modern living as seen through eyes sharpened by 50 years of practice.

The Doctor Looks at Life, by Peter J. Steincrohn, M. D., ($3.50. *Greystone Press, New York 13, N. Y.).* The author of **How to Stop Killing Yourself, More Years for the Asking,** and half a dozen other popular books on this theme now gives us his private, intimate views on Life, Love, Health, and Happiness.

Exploring Nature with Your Child, by Dorothy Edwards Shuttlesworth, ($3.95. *Greystone Press, New York 13, N. Y.),* is an introduction to the enjoyment and understanding of nature by the editor of *The Junior Natural History Magazine* of The American Museum of Natural History. Certainly there is no better way to come to know your child than by studying and sharing Nature with him.

Monographs in Medicine, edited by Wm. B. Bean, M. D., Series I, ($12.00. *Williams & Wilkins Co., Baltimore, Md.),* is an attempt to pick up the loose strings in medicine and give a comprehensive summary of current topics in

medicine. At this level of writing, the new series has justified itself and will prove a welcome addition to the library of the physician who is too tied down to travel and too busy to wade through the many journals on clinical medicine.

The Origins of Love and Hate, by Ian D. Suttie, M. D., ($4.00. *The Julian Press, New York 18, N. Y.),* is an original and one of the most important books in the field of psychology. Hate is presented as a frustration of the love needs. Then too, the book emerges as the first really comprehensive and constructive criticism of Sigmund Freud and the contradictions and dissensions on psychoanalysis.

Rheumatic Diseases—Diagnosis and Treatment, by Eugene F. Traut, M. D., ($20.00. *C. V. Mosby Company, St. Louis, Missouri).* This book of nearly 1000 pages deals with all phases of the subject and related conditions in a most comprehensive manner. With 30 million Americans having a deep concern about this matter because they or some member of their family are its victim, such a complete treatise becomes of great importance to all of us.

Synopsis of Eugen Bleuler's Dementia Praecox or, The Group of Schizophrenias, by Nathan S. Kline, M. D., ($1.25. *International Universities Press, Inc., New York 11, N. Y.),* applies Freud's ideas to the problem. Note is made that the work was completed in 1908.

Woman's Medical Problems, by Maxine Davis, ($1.49. Second Edition. *Grosset & Dunlap, Inc., New York 10, N. Y.).* Compiled by a competent science writer with a blessing in the form of a Foreword by Fred Adair, M. D., the work is a definite contribution to modern "health" writing.

Lives in Progress—A Study of the Natural Growth of Personality, by Robert Winthrop White, ($3.00. *Dryden Press, New York 19, N. Y.).* Based upon 15 years of case studies of normal people, the book provides an excellent introduction to the whole field of personality. The author uses the old method of case histories to introduce and illustrate general concepts drawn from a variety of sources that go to make up a personality.

Dynamic Psychiatry, Volume 3 — Frustrated Women, by Louis S. London, M. D., ($3.00. *Corinthian Publications, Inc., New York 16, N. Y.),* presents the case histories of 16 women who have frustrations according to Freud's definition.

How to Overcome Sex Frigidity in Women—A Guide to Proper Sex Behavior, by I. Devensky, ($2.00 cloth, $1.00 paper. *William-Frederick Press, New York City),* is an excerpt from the author's forthcoming book, **Sexual Incompatibility Prevented and Corrected.** Serves as a family guide which should be read aloud by the couple together.

The Low Fat Diet Cook Book, by Dorothy Myers Hildreth, Dietitian, and Eugene A. Hildreth, M. D., ($2.95. *Medical Research Press, New York 17, N. Y.).* To the increasing number of physicians who are treating arteriosclerosis by dietary means, this book with its 200 and more appetizing recipes will prove most helpful.

Circus Doctor, by J. Y. Henderson and Richard Taplinger, ($0.25 paper. *Bantam Books, 25 West 45th St., New York, N. Y.),* is the true story of the 700 animals belonging to "The Greatest Show on Earth," their habits, their diseases and their care, by the chief veterinarian to Ringling Brothers and Barnum and Bailey, now in a pocket edition.

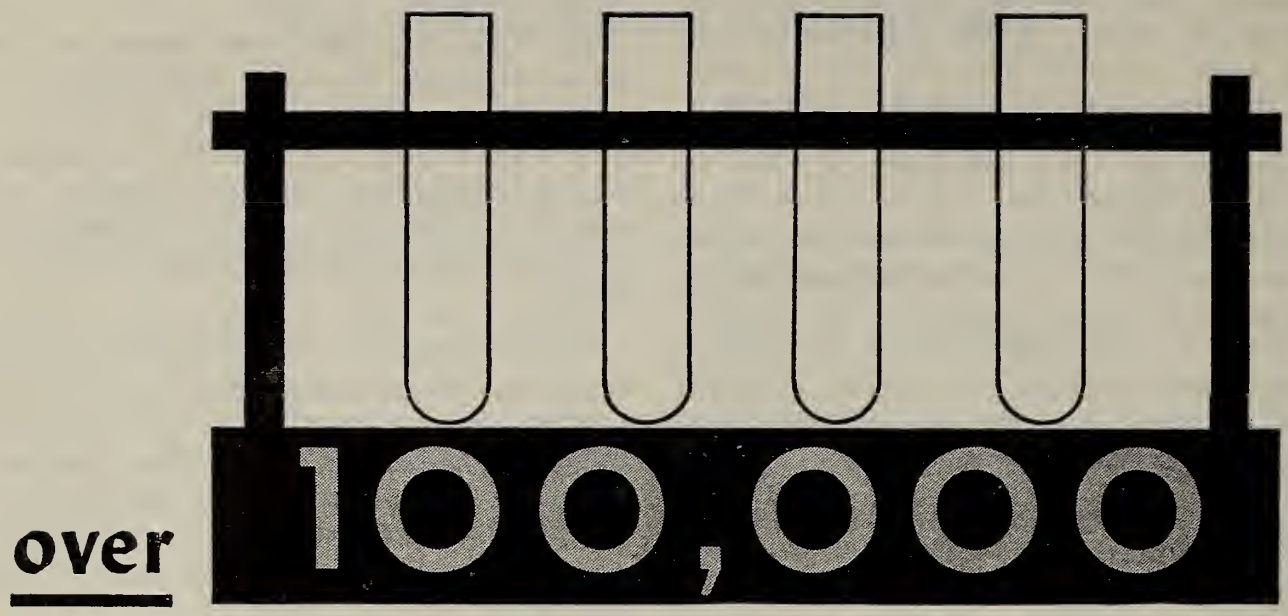
Principles and Practice of Aviation Medicine, by Harry George Armstrong, M. D., Surgeon General, U. S. Air Force, ($7.50. Third Edition. *Williams & Wilkins Company, Baltimore 2, Md.).* Since flying has become a part of our everyday lives, any physician may be called upon anytime to move his patient by air or to assist in air rescues. This book is therefore needed by all of us.

Therapy Through Hypnosis, edited by Raphael H. Rhodes, ($3.75. *The Citadel Press, New York 10, N. Y.),* explains how hypnosis has been used to cure diseases of mind and body.

The Autonomic Nervous System, by James C. White, M. D., ($12.00. *Third Edition. Macmillan Company, New York 11, N. Y.)*—A revised edition designed to incorporate the essentials from the great mass of important data from wartime and civilian experiences of the past 10 years.

Scalpel, by Horace McCoy, ($3.50. *Appleton-Century-Crofts, Inc., New York, N. Y.).* A brilliant surgeon in love with one woman, attracted to another—one of them the financée of his close friend; both of them his benefactresses, we find our surgeon in the midst of the conflict and confusions, which go to make the plot of this entertaining novel. How he comes to a full realization of his own destiny makes an absorbing story.

Conversation and Communication—A Psychological Inquiry into Language and Human Relations, by Joost A. M. Meerloo, M. D., ($4.00. *International Universities Press, New York 11, N. Y.).* Modern psychology and psychoanalysts have given us much new material on human expression and understanding. This book is based upon 25 years experience in a "word laboratory." Anyone interested in somatics and the processes of conversation will find this work valuable—and who isn't, with the demagogues ruling the United States of America for the past 30 years?



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JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

The Epiploic Appendages as a Cause of Abdominal Symptoms

Report of Three Cases and Brief Review of the Literature

WESLEY FURSTE, M. D., and JEROME M. RINI, M. D.

THE epiploic appendages may be responsible for clinical pictures simulating acute appendicitis, acute cholecystitis, intestinal obstruction, and other abdominal conditions demanding surgical intervention. The following three case reports and brief review of the literature are presented to emphasize that the epiploic appendages may be the cause of abdominal symptoms. When a definite pathological condition is not readily apparent at laparotomy performed for the treatment of acute abdominal symptoms, the epiploic appendages should be carefully examined.

CASE REPORTS

Case 1: The patient, an 18 year old white male college student, entered University Hospital on May 24, 1948, complaining of right lower quadrant pain. Dull aching pain had appeared 24 hours prior to admission and had persisted.

On examination of the abdomen, there was localized right lower quadrant guarding and tenderness with rebound tenderness referred to the right lower quadrant. Admission leukocyte count was 10,500 with 65 per cent neutrophils. Roentgenograms of the abdomen and chest were negative. The patient was hydrated with 5 per cent glucose solution.

Four hours after admission, his temperature was one-half degree above the initial level of 37.4°C.; and the leukocyte count was 11,950 with an unchanged differential. Since the abdominal findings persisted, the patient was taken to the operating room with the preoperative diagnosis of acute appendicitis.

A gangrenous epiploic appendage was found arising from the anterolateral aspect of the cecum. The distal end of it was lying free. This portion was removed, the proximal end was sutured to the cecum, and an appendectomy performed. The postoperative course was entirely uneventful, and the patient was discharged ambulatory on the fifth postoperative day.

Pathological examination of the tissue showed a necrotic hemorrhagic piece of adipose tissue (Figure 1). During the four years since operation, the patient has not had a recurrence of his abdominal symptoms, and has enjoyed excellent health.

Case 2. The patient, a 60 year old white female, entered St. Francis Hospital on November 23, 1950, complaining of right lower quadrant pain. Twenty-four hours prior to admission, the patient awoke with aching and intermittent, sharp, right lower quadrant pain which was accentuated by motion. There was no nausea, no vomiting, and normal bowel function. The pain became less but recurred the day of admission to the hospital.

On examination, her temperature was 36.7°C. The abdomen was obese and soft, and normal bowel sounds were heard. There was marked right lower quadrant tenderness and guarding.

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The Authors

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● Dr. Rini, Columbus, Ohio, at present Captain in the United States Army Medical Corps, is stationed overseas.

There was localized tenderness over McBurney's point and rebound tenderness in both lower quadrants. The total leukocyte count was 8,150.

The preoperative diagnosis was acute appendicitis, and the patient was prepared for emergency surgery. On opening the abdomen, a black piece of fat was present on the cecum. It was found to be a gangrenous epiploic appendage. This was removed, and an appendectomy was performed. The postoperative course was relatively benign except for a temperature elevation of 38.3°C. on the second postoperative day.

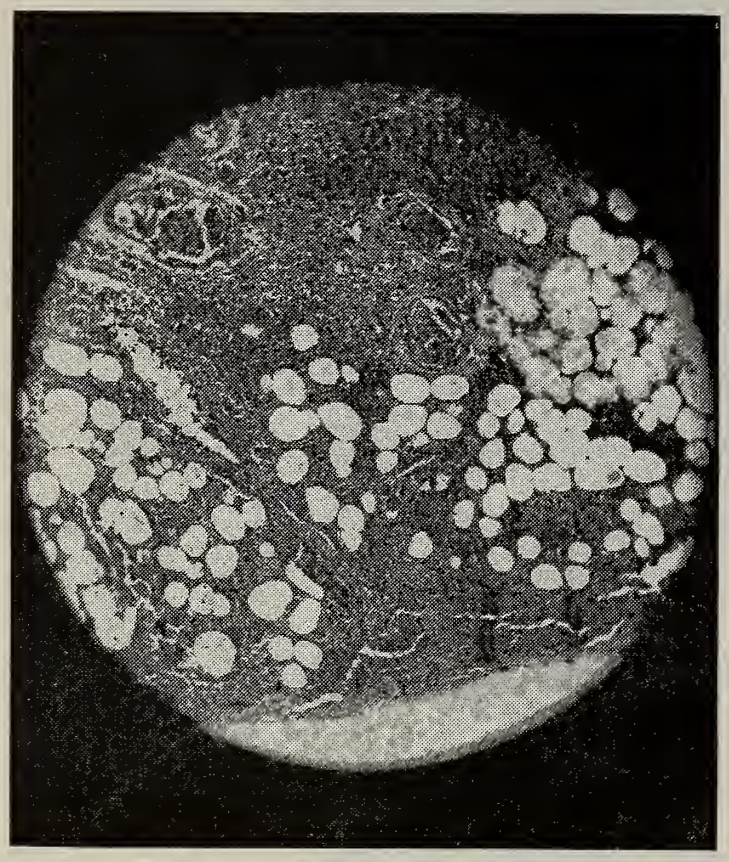


Fig. 1. Photomicrograph of specimen from case 1 (Table 1) in which a gangrenous epiploic appendage was found. Note the infiltration with inflammatory cells.

Pathological examination of the specimen showed a fragment of necrotic fat which was covered with a small amount of fibrinopurulent exudate. On examination 20 months following surgery, the patient stated she had been free of abdominal complaints; and appeared to be in excellent health.

Case 3. The patient, a 28 year old white male, entered St. Francis Hospital on November 27, 1951, complaining of sharp pain in the right lower quadrant of 24 hours duration. There had not been any vomiting or constipation.

On examination, his temperature was 36.7°C. There was finger point tenderness about four cm. medial to the right, anterior, superior, iliac spine. Peristaltic sounds were hyperactive. The initial leukocyte count was 10,000 with 80 per cent neutrophils.

With a preoperative diagnosis of acute appendicitis, the patient was taken to the operating room. On opening the abdominal cavity, some free fluid was found to be present; and an edematous, inflammed epiploic appendage was seen just distal to the cecum in the region of the anterior taenia. The appendix itself was lateral and retrocecal, and bound down by numerous adhesions. The diseased appendage was removed, and an appendectomy was performed.

The pathological diagnosis was "infarcted epiploic appendage." The postoperative course was uncomplicated. Eight months after the operation, the patient was in excellent health, and had gained 18 pounds in weight.

The foregoing cases illustrate the difficulty in making a correct preoperative diagnosis when there is disease of the epiploic appendage. Symptoms of about 24 hours' duration were sufficient to warrant exploration. Since all three of these diseased appendages were located on or very near the cecum, the clinical picture closely resembled that of acute appendicitis.

Abdominal pain was a constant finding although the character of the pain varied from sharp and intermittent to dull and constant, as noted in Table 1. This was the first episode of such pain in these three cases. Nausea and vomiting were not present, nor was there any change in bowel habits. In only one of the three cases was fever present. Leukocytosis was not a prominent part of the clinical picture.

TABLE 1. DATA ON THREE CASES ADDED TO THE LITERATURE WITH THIS REPORT

Case No.	Duration of symptoms	Pain	Nausea	Vomiting	Constipation	Nutrition	Initial temperature: degrees Centigrade	Tenderness	Abdominal guarding	Abdominal mass	WBC/cu. mm.	Preop. Diagnosis	Postop. Diagnosis	Result
(1) 18 year old white male	24 hrs.	Dull aching RLQ	No	No	No	Well developed	37.4	RLQ	Yes	No	10,500	Acute appendicitis	Gangrene	Excellent
(2) 60 year old white female	24 hrs.	Sharp intermittent RLQ	No	No	No	Obese	36.7	RLQ	Yes	No	8,150	Acute appendicitis	Gangrene	Excellent
(3) 28 year old white male	24 hrs.	Sharp intermittent RLQ	No	No	No	Well developed	36.7	RLQ	Yes	No	10,000	Acute appendicitis	Infarction	Excellent

Localized tenderness and guarding were the most consistent findings. It was because of this persistent and localized tenderness that surgery was performed.

DISCUSSION

Pathologically, the epiploic appendages are subject to torsion, acute inflammation, detachment, and the formation of adhesions.[4] When torsion occurs, the appendage may become strangulated due to interference with its blood supply so that infarction progressing to gangrene occurs. The exact cause of the torsion

TABLE 2. ONE HUNDRED TWENTY PREVIOUSLY REPORTED CASES IN WHICH THE EPIPLOIC APPENDAGES HAVE BEEN RESPONSIBLE FOR ABDOMINAL FINDINGS AND IN WHICH LAPAROTOMY WAS PERFORMED

Author	Year of Report	Pathological Conditions of Epiploic Appendages	No. of Cases	No. of Deaths	Preoperative Diagnoses When Given	Comment
Baumeister, Hargens, and Morsman[1] (not cited by Giffin et al.[9])	1938	Adhesions between epiploic appendages causing large bowel obstruction	1	1	Acute mechanical obstruction of the large bowel	
Moore, G. A.[18] (not cited by Giffin et al.[9])	1940	Torsion Incarceration of epiploic appendage in left scrotal hernia Adhesions between epiploic appendage and parietal peritoneum Adhesions between epiploic appendage and base of mesentery of small bowel	5	1	Small bowel obstruction	A 75 year old man with intestinal obstruction due to an adhesion between an epiploic appendage and the parietal peritoneum died of pneumonia on the 7th postoperative day.
Mabrey [15] (not cited by Giffin et al.[9])	1940	Infarction Strangulation Gangrene	6	0	Acute appendicitis Possible partial obstruction Possible diverticulitis	In 1 case which was operated in 1914 the "strangulated epiploic appendix" was inaccessible, and it was not removed. Patient continued to have pain and spasm for 10 days.
Giffin, McManamy, and Waugh [9]	1942	Torsion Infarction Inflammation	59	3	Torsion of an epiploic appendage [8] Strangulated hernia Acute appendicitis Abdominal colic Acute diverticulitis Acute cholecystitis Acute epiploitis Twisted ovarian cyst Sigmoid tumor Meckel's diverticulum Sigmoiditis with perforation and abscess of abdominal wall Pelvic inflammation Abdominal malignant disease Intestinal obstruction	Giffin et al. found 49 cases in the literature, and reported 10 of their own.
Moore, G. H.[19]	1942	Torsion	1	0	Acute appendicitis	
Paul[21]	1942	Torsion	1	0	Acute appendicitis	
Harte[10]	1943	Intussusception of epiploic appendage	1	0	Chronic partial intestinal obstruction of mid-sigmoid due to carcinoma	Barium enema on 3 occasions indicated complete obstruction at the mid-sigmoid.
Kirkham and Zerlin[13]	1943	Torsion	1	0	Acute Appendicitis	
Porter[23]	1943	Torsion	1	0	Diverticulitis	There were 2 complete turns of pedicle.
Rose[26]	1945	Incarcerated cyst of an epiploic appendage in a McBurney incision hernia	1	0	Incarcerated omentocele in a McBurney incision hernia	
Byberg and Lam [5]	1945	Acute inflammation	1	0	Intra-abdominal testicle, sigmoid diverticulitis, or left sided vermiform appendicitis	
Simpson [31]	1945	Hemorrhage and infarction	2	0	Appendicitis Diverticulum of sigmoid	
Ives[11]	1946	Gangrene	2	0	Acute appendicitis	
Schimberg and Allen[29]	1947	Torsion	1	0	Appendicitis	
Marbury and Jackson[16]	1948	Gangrene	1	0	Appendicitis	
Rosenak and Young[27]	1948	Edema of epiploic appendage due to portal cirrhosis	1	0	Abdominal masses of undetermined etiology	The transverse and sigmoid colon were palpated as large cylindrical masses because the epiploic appendages were so extremely large and edematous.
Tatarowicz and Shambaugh[32]	1948	Infarction	1	0	Diverticulitis or left sided appendicitis	
Cambell and Canipelli [6]	1949	Infarction	2	0	Acute appendicitis Acute appendicitis or acute diverticulitis	
Jenkins[12]	1949	Torsion	1	0		

(Continued on Page 404)

TABLE 2. ONE HUNDRED TWENTY PREVIOUSLY REPORTED CASES IN WHICH THE EPIPLOIC APPENDAGES HAVE BEEN RESPONSIBLE FOR ABDOMINAL FINDINGS AND IN WHICH LAPAROTOMY WAS PERFORMED.

(Continued)

Author	Year of Report	Pathological Conditions of Epiploic Appendages	No. of Cases	No. of Deaths	Preoperative Diagnoses When Given	Comment
Quilliam[24]	1949	Torsion	1	0		Five days after dilation and curettage for incomplete abortion, patient developed pain in lower abdomen, and laparotomy was performed.
Marinis and Cheek[17]	1949	Gangrene	6	0	Acute appendicitis	
Wakeley and Childs[33]	1949	Torsion	8	0	Acute appendicitis Torsion of the left ovary	
Ladin[14]	1949	Torsion Gangrene Torsion in an incarcerated inguinal hernia	5	0	Twisted ovarian cyst Acute appendicitis Incarcerated inguinal hernia	
Rosenbaum and Kissinger[28]	1950	Infarction	3	0	Acute appendicitis	
Beattie [3]	1950	Infarction	2	0	Acute appendicitis	
Wilensky[34]	1950	Acute suppurative inflammation	1	0	Adhesions	
Bearse [2]	1952	Calcified appendix epiploica Torsion Torsion and infarction	5	0	Calcified mesenteric lymph node ? appendicitis or ? torsion of appendix epiploica Acute appendicitis Acute diverticulitis of sigmoid Acute cholecystitis	
Total			120	5		

is uncertain. It is quite probable that a certain number of cases with unexplained mild attacks of abdominal pain are due to subacute or chronic torsion of one or more of the epiploic appendages.

Diseases of the epiploic appendages are most commonly seen between the ages of 18 and 60. Often, there is a history of previous attacks of abdominal pain. The current attack lasts from a few hours to a week. Abdominal pain is the chief complaint; it may be gradual or sudden in onset, and is described as aching, sharp, or colicky. The site of the pain varies with the position of the affected appendage.[33] Torsion of an appendage of the sigmoid colon causes pain in the left iliac fossa, and torsion of an appendage of the cecum gives rise to pain in the right iliac fossa.[5, 33]

The patient is usually not severely ill. The temperature may be slightly elevated to about 37.5°C. Nausea and vomiting may occur. Usually, the appetite and bowel function are unaffected or only slightly altered.

Examination of the abdomen shows signs dependent on the site of the involved appendage. Muscle guarding of varying degrees and marked local tenderness are found over the involved appendage, and there may even be rebound tenderness. Hyperesthesia of the skin over the affected area has been noted.[22] In some cases, a mass may be felt in the abdomen.

If a strangulated epiploic appendage is lying free in the pelvis, rectal examination may disclose tenderness and occasionally a mass. An epiploic appendage which undergoes torsion within a hernial sac will give the signs of a strangulated hernia.[14, 26] Cases in which an appendage has formed an inflammatory band and in which the bowel has become obstructed will exhibit the signs of intestinal obstruction.[1, 10, 18] In some of the more severe cases, polymorphonuclear leukocytosis occurs.

The preoperative diagnosis of disease of the epiploic appendage is very difficult because of the rarity of the condition and the frequency with which other forms of intraperitoneal irritation are seen. In the 120 previously reported cases, as summarized in table 2, only one case was found in which a correct preoperative diagnosis was made. Fiske[8] points out that a correct diagnosis of torsion of an epiploic appendage was made by Babcock prior to operation on a 42 year old female. This patient's vermiform appendix had been removed 22 years previously; and a deep-lying, tender, nodular mass was palpated about mid-way between the left, anterior, superior, iliac spine and the umbilicus.

It is generally agreed by all who have written on the subject that the treatment of choice is excision of the involved epiploic appendage. In the three cases reported initially in this paper, an appendectomy was also performed, and had no apparent untoward effect.

In the 123 cases, including the three reported for the first time in this paper, there were five

deaths.[1, 7, 18, 25, 30] All of these deaths which were in the postoperative period occurred before 1942, and were due to one of the following causes: bowel obstruction caused by a band attached to an epiploic appendage, generalized peritonitis following drainage of an abscess resulting from a twisted gangrenous epiploic appendage, paralytic ileus, and pneumonia.

SUMMARY AND CONCLUSIONS

Three cases of diseased epiploic appendage are added to the 120 previously reported cases of epiploic appendage which have been responsible for a laparotomy. Cases of pathologically altered epiploic appendages which have not necessitated abdominal exploration are not included in this series. It must be emphasized that the diagnosis of a diseased epiploic appendage should be considered in the face of a negative laparotomy and the clinical picture of a surgical abdomen. A thorough search for such an appendage should be made before the abdomen is closed.

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Coronary Artery Disease Treatment

Khellin (visammin) is a di-methoxy-methyl-furano-chromome derived from an eastern Mediterranean plant known as Ammi visnaga. It is said to relax visceral smooth muscle by direct action on the muscle fibre. Although there have been some favorable reports and it seems worth a trial in any patient with troublesome angina pectoris, I have not found many patients who have been much relieved by it and several for whom it has been prescribed have been rather distressed by its side effects.

Atropine and its derivatives are not used as widely as they might be in patients with cardiac pain. Tincture of belladonna in full dosage is often of considerable help, and this is particularly true if the patient also has chronic cholecystitis or certain chronic gastrointestinal disturbances.—Francis F. Rosenbaum, M. D., Milwaukee; *Wisconsin Medical Journal*, 51:990, October, 1952.

Intestinal Obstruction Due To Impacted Gallstones

I. HENRY EINSEL, M. D.

INTESTINAL obstruction due to impacted gallstones is a rare condition. A case showing the gastrointestinal x-ray of the gallstone previously and its erosion pathway into the gastrointestinal tract ten years later is still more unusal.

Karl Meyer and J. L. Spivach, *Annals of Surgery*, 1934, reviewed 505 cases of intestinal obstruction at the Cook County Hospital and found two such cases, giving an incidence of occurrence of 0.4 per cent. In all literature. according to W. A Calihan and Harold F. Hulbert in an article published in *The Journal of the International College of Surgeons*, September, 1951, Vol. XVI, No. 3, the first case was reported by Bartholine in 1654, but it was not until 1890 that the first article was published by Courvoisier.

ETIOLOGY

Patients with impacted gallstones have a history of chronic gallbladder disease over a long period of time. In order to avoid this condition a diagnosis of chronic cholecystitis with lithiasis could have and should have been made at a much earlier date. Elective surgery is the best method of preventing this serious complication with its resulting high mortality.

Practically all of these patients with intestinal obstruction are in the old age group, therefore, the mortality is high and is reported as ranging between 50 per cent and 80 per cent. In all series, women are more frequently found than men.

THE MECHANISM OF THE OBSTRUCTION

In the following ways stones enter the gastrointestinal tract:

1. Through ulceration of gallstone through the gallbladder into the duodenum.
2. Through ulceration of a stone in the common bile duct into the duodenum.
3. Dilatation of the cystic and common ducts large enough to eject the stone into the gastrointestinal tract.

AGE AND SEX FACTORS

The ages of our two women patients were 71 and 84. This follows the reported curves of 16 female to 1 male.

CLINICAL SYMPTOMATOLOGY

Clinical symptomatology of the gallstone intestinal obstruction should be divided into four periods:

1. If time and care is taken a history of chronic cholecystitis can be obtained.
2. First there is a severe pain in the epigastrium when the stone ulcerated into the gastrointestinal tract. This is followed rapidly by almost projectile vomiting with no retention of food or fluid. This period may last 24 hours.
3. Examination shows the picture of small bowel obstruction with tenderness around the umbilicus. The right lower quadrant of the abdomen is rather sensitive. (The pain in our two cases was localized around the umbilicus and referred to the right lower quadrant.) This period lasts several days.
4. The final picture is that of small bowel ileus with toxemia and peritonitis due to perforation at the obstructed point where the gallstone is impacted. This may take a week or less.

DIAGNOSTIC PROCEDURES

Naturally a good history is most important, followed by good flat plate of entire abdomen made with a Bucky in order to see the point of

Submitted October 27, 1952.

The Author

● Dr. Einsel, Cleveland, is visiting surgeon at Woman's Hospital, Cleveland, Ohio.

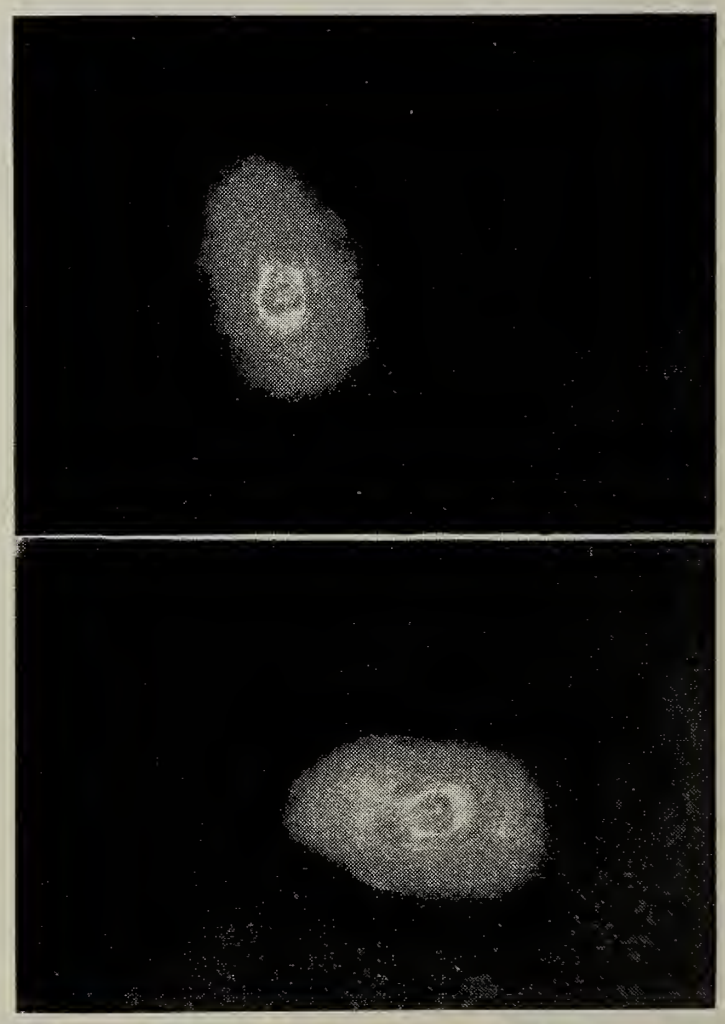


Fig. 1. Shows roentgenogram of the gallstone that was removed at operation with its nidus, as the previous gallstone seen by x-ray ten years previously.

dilatation of small bowel. This varies from case to case, depending upon the size of the gallstone and how far it can get down the small bowel before it becomes impacted. Some occur in the upper third, some in the middle, and some just before the ileocecal valve. From an operative point of view the last is the worst point for more bacteria are present and the patient is very toxic from the obstruction.

The usual blood examination and blood chemical analyses including blood urea to exclude toxemia, blood globulin and albumin, and protein



Fig. 2. An actual photograph of stone secured at operation (Case I)—the larger of the two stones. The small stone is from patient 84 years of age (Case II).

should be made to determine the necessary protein requirements. Fluids of saline and glucose and blood transfusions are in order.

Surgery should not be put off because of the condition of the patient. The course is always down hill and the mortality is high. Procrastination usually ends in death.

PROPHYLAXIS

In one of our cases (Case I), the patient had a cholecystography some ten years before, at

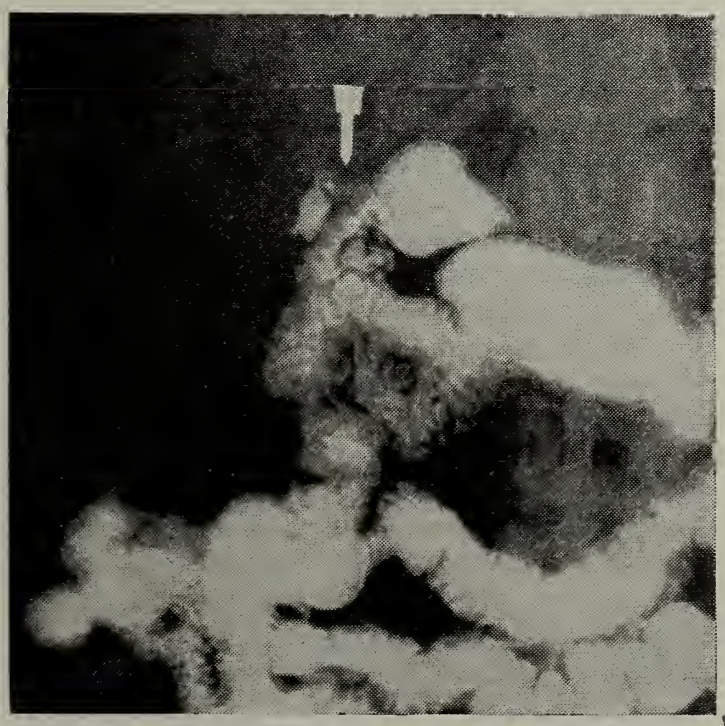


Fig. 3. An unsuccessful attempt to visualize the hepatic ducts postoperatively.

which time a calcified stone in the gallbladder was demonstrated and surgery was advised but the patient refused. The gastrointestinal roentgenographic study shows a stomach which is normal and a signet ring cholesterol calcified stone. The second portion of the duodenum is slightly irritable. We feel this is the first case where a roentgenogram was made of stone and gallbladder before the catastrophy took place.

Following the operative procedure it was thought advisable to repeat the gastrointestinal study to see if the fistulous tract could be visualized. This was done about two months postoperatively. The roentgenogram shows the gallbladder was reduced in size and the perforating fistula was almost as large as the gallbladder. The cystic duct was not patent for no barium is in the common duct or the duct radicals. (See figure 3.)

If this patient had accepted the advice given ten years before, the catastrophy would not have

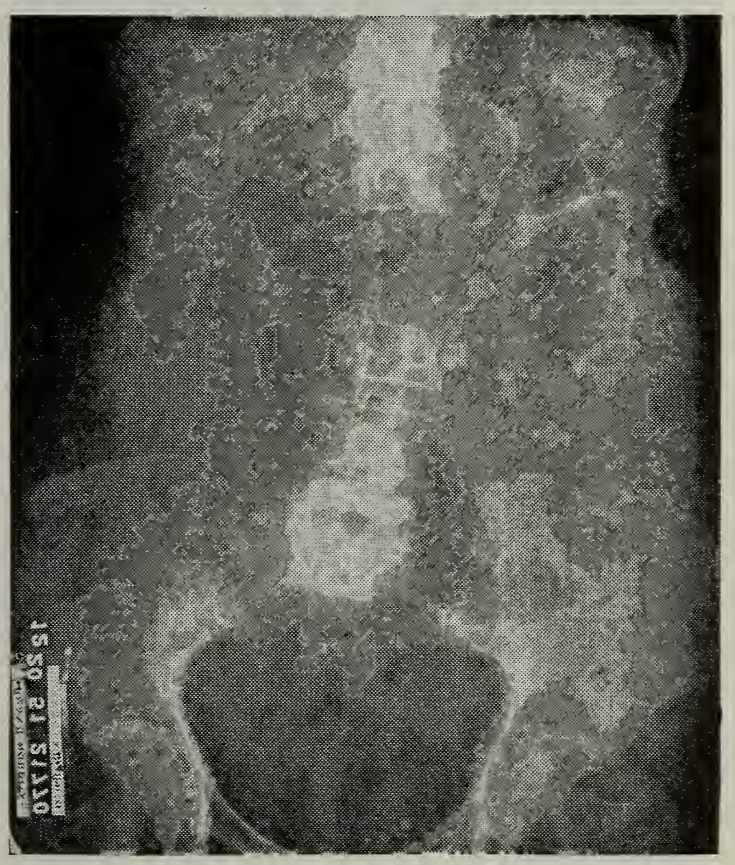


Fig. 4. Small bowel obstruction (Case I).

occurred. If expedient and successful surgery had not been performed death would have ensued.

The lesson to be learned in cases such as this where there is a history of chronic gallbladdder disease and obstructing stones is that surgery should be performed. In this way can be prevented the possibility of intestinal obstruction —one of the catastrophic things that can happen to many cases of this type.

REPORT OF CLINICAL CASES

Case I. The patient, age 71, was admitted to the Woman's Hospital, Cleveland, Ohio, December 20, 1951, with chief complaint of vomiting and severe pain. The pain had started five days previously in the upper abdomen, and now had shifted to around the umbilicus and slightly

to the right below. There was 2 plus tenderness and a questionable mass to the right of the umbilicus.

Past History. The patient had typhoid fever at the age of 15 and a history of chronic gallbladder disease starting more than ten years previously when roentgenogram had been taken. The author had advised surgery at that time which the patient refused.

Physical examination showed evidence of dehydration from the vomiting, skin lost turgor, tongue dry. Abdomen showed some distention but not too much for the vomiting had performed decompression. There was tenderness and a questionable mass around the umbilicus and some tenderness toward the right lower quadrant.

Laboratory Findings: White blood cells, 6,350; red blood cells, 4,800,000; hemoglobin 84—high because of dehydration. X-ray showed small bowel obstruction present. Figure 4 shows this obstruction.

Operation: Surgery was performed December 21, 1951, under continuous pontocaine® glucose spinal anesthesia. A mid right pararectus incision was performed and the gallstone was found two-thirds way down the ileum. The small bowel was enlarged to about three inches in diameter. Where the stone was impacted the bowel was getting dusky and the serosa showed some fibrin.

At this stage the following procedure was undertaken. By gentle manipulation the stone was found and moved up the bowel about two feet where the colon looked better. The loop was isolated and packed off with tapes and clamps. Soft rubber compression intestinal clamps were applied, this keeping the intestinal contents away from the incision; a cut was made over the gallstone just large enough so that the stone could be removed by dilating the small intestine. After removal it was closed transversely with No. 00 chromic catgut approximating the mucosa by locking stitch. The second layer used in the closure was by interrupted No. 2 silk sutures. By this means the opening in the intestine was closed tightly. The abdomen was closed in layers in the usual manner, No. 1 chromic continuous to peritoneum, No. 1 to outer fascia interrupted. Clips and silk were inserted in closing the skin.

The patient made an uneventful recovery with rectal temperature of 100°F. on the second postoperative day.

Case II. The patient, age 84, admitted to the hospital May 13, 1949, was operated upon on the same day. Her history was difficult to get because of her senility. Four and one-half days before admission severe pain and vomiting, as in Case I, had started, beginning in upper abdomen and going to the area of the umbilicus and somewhat toward the right lower quadrant. She had more distention and clinically was in worse shape than the patient in the previous case.

Physical examination showed marked dehydration, skin turgor poor, tongue very dry. Blood pressure 120/80, urine showed casts and occasional white blood cells and red blood cells. White blood cell count was 15,550, red blood cells 5,230,000, hemoglobin 97 per cent. Roentgenogram showed small bowel obstruction.

Operation: Operative procedure was the same as described in Case I. The stone is shown in figure 2. It is the smaller stone and faceted in type. Only one stone was found in each case. The entire small intestine was explored. After moving the stone to where the blood supply of the small intestine was better, it was removed by the same technique as previously described.

Following the operation the patient was very ill for a week but finally convalesced. She is still alive at this writing at the age of 87 and has no symptoms referable to the biliary tract.

SUMMARY

1. This is a report of the successful handling of two intestinal obstructions due to gallstones. Exploration in both cases showed marked adhesions at the gallbladder area to the duodenum. These were not disturbed because condition of the patients did not justify it.

2. The importance of mobilizing the stone to an area of the intestine where there is no question of blood supply, is to be emphasized. This procedure finds a safe place in the intestine to incise, remove and repair the bowel with less chances of subsequent leakage and danger of peritonitis.

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Increasing Incidence of Coronary Arteriosclerosis in Diabetics

The chief cause of death in diabetics with onset of the disease in adult life is now coronary arteriosclerosis.

Because of the many recent advances in the therapy of diabetes, the problems of this disease are continually changing. That degenerative vascular lesions are now responsible for the vast majority of deaths in diabetics with onset of disease in adult life is shown by recent autopsy statistics. These statistics illustrate the remarkable decline in the incidence of coma, infection, and gangrene as causes of death and show an incidence of myocardial infarction higher than has been previously reported.

Wilson and Joslin have shown that the majority (51.9 per cent) of childhood diabetics who die between the ages of 25 and 40 years die of degenerative kidney disease. The observations of Root, Sinden, and Zanca indicated that among young patients whose diabetes began between the ages of 15 and 30 years, the degree to which diabetes was controlled by careful observation of diet prescription, and by adjustment of insulin dosage in the attempt to maintain a sugar-free urine, was correlated with the postponement and prevention of vascular changes. This point was clearly substantiated by the data of Wilson, Root, and Marble upon 247 patients with diabetes beginning between ages of one year and 29 years. —Howard F. Root, M. D., Boston, and Kelly M. West, M. D., Oklahoma City; *J. Oklahoma S.M.A.*, 46:6, January, 1953.

Photographic Evidence of Improvement After Stellate Ganglion Block Treatment of Acute Cerebrovascular Accident

WILLIAM R. CHAMBERS, M. D.

MANY thousands of words have been written, pro and con, as to the value of stellate ganglion block in acute cerebral thrombosis and embolism. Results of animal experiments have not indicated a sufficient control of the sympathetic nervous system in the regulation of cerebral blood flow to justify its use on theoretical grounds.[1, 2] On the other hand, clinical evidence has been amassed by many in support of favorable results on patients.[3, 4]

A recent editorial in the journal of *Surgery, Gynecology and Obstetrics* by John E. Adams[5] has called attention to the controversy. Nowhere, however, has the author seen incontrovertible photographic evidence of the favorable results sometimes obtained clinically. The following case would seem to fill that void.

CASE REPORT

A 33 year old white female was admitted to the Elkhart General Hospital, Elkhart, Indiana, on May 18, 1951, following a motorcycle accident. Roentgenograms showed "intertrochanteric fracture of the left hip, with some comminution and with displacement. There was also a fracture of the middle third of the left femur, with displacement and a fracture of the supracondylar region of the left femur."

The same day, a Kirschner wire was inserted through the upper tibia, and the leg was placed in a Thomas' splint. On June 20th, open reduction of the hip with a Smith-Petersen nail was undertaken. A loose piece of bone was removed.

About July 1, 1951, the patient began having intermittent headaches. On July 20th, there was a sudden onset of severe pain in the left forehead, diplopia, and droop of the left lid, which quickly progressed to complete lid drop. The pupil was dilated and ophthalmoplegia was noted, except for external rotation of the eye.

The next evening, while being examined, the patient had a Jacksonian convulsion, beginning in the right face and progressing over the whole right side. The head and the eyes turned to the left. About ten minutes later, after the convulsion had subsided, she had a diencephalic storm, with flushing, profuse sweating, vomiting, palpitation, and acceleration of the pulse to 180. There was incontinence of urine. Headache was extreme. Petechiae were noted on the chest and abdomen.

Stellate ganglion block was done on the left with cessation of the headache and vomiting within ten minutes and disappearance of the palpitation and tachycardia. Encouraged by this result, stellate ganglion block was done the next morning on the right. To everyone's amazement, the left eye popped open, the dilatation of the pupil relented somewhat, and a partial ability to turn the left eye inward returned.

In eight hours these results regressed to their former state, but a repeat block on the right, again resulted in the same amazing improvement, and this time it was photographed. The pictures, figure 1 and figure 2, are presented in evidence.

Submitted September 25, 1952.

The Author

● Dr. Chambers, Cincinnati, is a member of the staff at Good Samaritan Hospital.

Repeated stellate ganglion blocks were done; improvement continued and began to be maintained. At the present writing, the patient has only a very minimal ptosis, the pupils are almost equal, and diplopia has practically disappeared.



Fig. 1. Appearance of Left Eyelid Before Right Stellate Ganglion Block; Patient Trying to Raise Lid.



Fig. 2. Appearance of Left Eyelid Ten Minutes After Right Stellate Ganglion Block.

The case was considered one of probable multiple fat emboli, although no free fat could be found in the sputum or the urine.

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Practical Considerations in Culdoscopy*

EDUARD EICHNER, M. D.

DECKER, in 1944, published the first of many articles describing culdoscopy and the culdoscope. Since then other authors have written enthusiastically of their experiences. The purpose of this paper is to present briefly a description and a few practical hints in the use of this instrument and its attachments (figure 1).

The Author

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DESCRIPTION

The cannula (A) has a collar at its distal end which prevents too deep entry into the pelvic cavity. The proximal end has a valve which when opened permits air or carbon dioxide to enter the abdomen before the trocar is withdrawn. This end also has the threaded lock which may hold the trocar or endoscope in position.

The obturator trocar (B) locks into the sleeve cannula for penetration of the cul-de-sac. On withdrawing the trocar a rush of air will be heard if gas has not already entered through the cannula valve.

The endoscopes (C and D) replace the trocar in the cannula for visualization of the pelvic viscera. Both work on AC or DC current through proper adapters and transformers, and may be used with any standard battery box. The basic culdoscope (C) has right-angle vision. At the eyepiece end is the straight rotating contact, or "frog," which permits free rotation of the instrument without tangling the cord. The second instrument (D) has lenses for retrograde vision. Between the two, the visual field extends beyond 145°.

The flexible metal cannula (E) with luer-lock adapters at each end, and the Huggins type cannula with luer-lock end (F) are used for uterotubal insufflation or for the injection of indigo-carmine. The dye can be seen escaping in peristaltic rushes from normal tubes. Dr. Decker has used and described operating culdoscopes. We have had no experience with them.

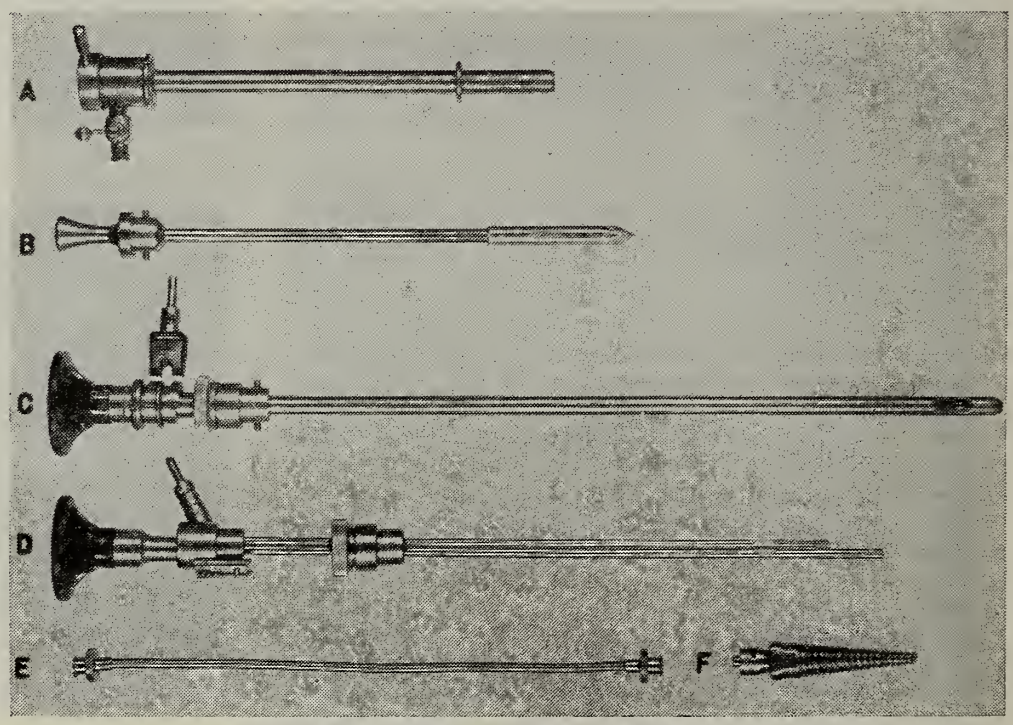


Fig. 1. Culdoscope and attachments.

PREOPERATIVE TREATMENT

Although culdoscopy can be an office procedure, hospitalization is preferred. Patients enter the hospital in the morning about one hour before scheduled operative time. They have had no breakfast, and should have had a good bowel movement before leaving home. Premedication is seldom necessary, but minimal sedation frequently allays the apprehension of the patient. On admission she is given routine perineal preparation. Patients void before getting on the operative table, but if catheterization is required it should be done in lithotomy or dorsal position, and never in knee-chest position unless air-cystoscopy is to be done. Catheterization in knee-chest position distends the bladder with air. This may displace the uterus up into the expected visual fields.

ANESTHESIA

If caudal anesthesia is used, it may be induced in the prone or knee-chest positions. Saddle block is also satisfactory, but this must be truly saddle, and not "low spinal." The preferred anesthetic is 2 per cent procaine local induced with the patient in knee-chest position after preparing the vulva and vagina with non-irritating antiseptics. On occasion I have used Ter-

*Read before the joint meeting of the Cleveland and Pittsburgh Obstetric and Gynecologic Societies, Cleveland, Ohio, March 25, 1952. (Case Report added later.)

ramycin vaginal suppositories or tablets for 48 hours preoperatively with no adverse effects.

The favored position for the patient is obtained by dropping the foot of the table to the vertical, and attaching to this a properly padded metal foot-board. This is placed about one-third of the patient's thigh length below the level of the table. The patient kneels on this rest, and then assumes knee-chest position. One shoulder-brace will keep her from slipping forward, and the position of the operator prevents backward slipping. A tablestrap may be used to support and brace her thighs at the table. However, so long as general or too-extensive regional anesthesia or excessive analgesia has not been used, complicated and cumbersome equipment is not needed to hold the patient in position.

TECHNIQUE

The posterior vaginal wall is elevated with a right-angle or Sim's type retractor, and the posterior lip of the cervix is grasped with a single or double-toothed non-cutting tenaculum. The vaginal vault bulges cephalad and may be infiltrated easily with 2 per cent procaine through a short-bevelled 20-22 gauge spinal needle. Frequently anesthesia is not necessary, as evidenced by the easy penetration of the needle followed by the rapid emptying of the syringe and the successful culdoscopy. Occasionally infiltration separates the peritoneum from the vaginal mucosa to an excessive degree.

When one to three ml. of solution has been used, the trocar, locked into the sleeve cannula, is pushed through the wheal in the vaginal vault into the pelvis. The cervix must be held steady by the operator, and the trocar's insertion must be in the midline just posterior to the cervix. The point should point ventrally, and the handle should be in contact with the Sim's speculum. If this is not done penetration may be into the base of the broad ligament or into the perirectal tissues. No harm has ever been done by this, but it is disconcerting to the uninitiated to see retroperitoneal vessels. Should this occur, the trocar should be re-inserted in the proper direction through the original vaginal opening. Occasionally it may be necessary to grasp and fix the peritoneum before pelvic entry is possible.

If carbon dioxide is to be used instead of air, a gas cartridge and the necessary tubing can be attached to the lock-valve of the cannula before the trocar is removed. The sleeve is left in situ. If carbon dioxide is not used, the rush of air into the pelvic cavity on the withdrawal of the trocar is evidence of successful penetration. The endoscope is then inserted, and culdoscopy is done. We no longer lock the culdoscope into the sleeve, preferring in most cases to keep the cannula fixed, and to move the 'scope. Visibility is increased by tenaculum manipulation of the cervix, and by pressure on the abdominal wall. These vary the positions of the pelvic organs. When inspection has been completed, the endoscope is withdrawn.

Pressure is applied firmly and deeply on the upper abdomen of the patient as she slowly slips into the prone position. Air is heard escaping freely from the cannula. Pressure is maintained for 30 to 60 seconds after the patient is flat on her abdomen before the sleeve is removed. She is returned to her room in her own bed, in the prone position which is maintained for an hour. Following this she is permitted to turn freely, and is discharged later in the afternoon with instructions to remain in bed one day. She does have bathroom privileges that day, but is asked that she be sparing in using this privilege. Thereafter, except for douches, tub baths, coitus, or work requiring kneeling she may do as she wishes.

All restrictions are removed at the end of the week, at which time the patient returns to the office for examination and discussion of the findings. In general, it has made little difference whether air or carbon dioxide has been used. Seldom has shoulder discomfort persisted over 48 hours, and never has it been severe enough to require more than one or two doses of aspirin and/or codeine.

DISCUSSION

In the development of our technique, anesthesia was the first difficulty to be overcome. All except local or minimal saddle add unnecessary handicaps to what should be a simple procedure. Caudal, when successful, is excellent, but requires more time for its induction. If anesthesia-induction rooms are not available, this may interfere with the operating room schedule. It is almost impossible to hold deeply sedated patients in knee-chest position, and occasionally scopolamine renders a previously willing subject uncooperative. Demerol® 0.1 Gm. given about one hour before culdoscopy is often all that is needed along with local procaine infiltration. This dose of demerol® will frequently keep the patient from becoming too restless, particularly so when the procedure is prolonged for the instruction of the house staff and other interested physicians.

It is almost impossible to do proper culdoscopic examinations on virgins, or women with inelastic perineal bodies or tight vaginal outlets. A spastic outlet greatly limits the maneuverability of the instrument, and thus interferes with adequate vision. It is in this type of patient that a relaxing anesthetic such as saddle or caudal is definitely indicated. It took about eight to ten examinations before we developed the skill necessary for the proper manipulation of the culdoscope and cervix which enabled us to view the entire pelvis. At about the same time we learned to

evaluate the degree of magnification present in the lens system.

It may be noted here that a sense of depth perception is required for best interpretation of the findings. The organs appear almost exactly as at laparotomy. Small and large bowel, the appendix, adhesive bands as well as all the pelvic viscera are readily identified. However, it is only the rare patient in whom the bladder dome and the anterior surface of the uterus may be satisfactorily seen. Occasionally the ovary hides the middle third of the corresponding tube. It is for this reason that the retrograde telescope is now an accessory instrument. As skill in the procedure develops the cervical tenaculum becomes an extension of one's fingers, rotating and manipulating the uterus quite freely.

A marker of some sort is necessary for the inexperienced. The early operator forgets that he and the patient are homologously placed, the opposite of the condition existing when examination is done in lithotomy position. The novice frequently forgets to check his lens, lights, cord and battery before the operation proceeds. Similarly, if vision is not satisfactory, he is reluctant to withdraw the telescope and wipe the lens, light or eyepiece. These often sweat, or are clouded by tissue fluids or pelvic fat. However, with increasing experience these hazards disappear as the various actions become second nature to the operating gynecologist.

INVALUABLE ADJUNCT TO DIAGNOSIS

The procedure of culdoscopy was started as an experiment at Mt. Sinai Hospital in 1950, and is now an integral part of the program in training residents. Its use has saved several patients from unnecessary operation; it has clarified discrepancies in hospital records and physical examinations; it has explained previously inexplicable cases of sterilty; and only once have the findings been misinterpreted in regard to ectopic pregnancy. The procedure has been done in bleeding patients and in those recently recovered from subacute pelvic peritonitis. Chronic pelvic inflammatory disease has not been an insurmountable obstacle as bands and pockets can be threaded by the culdoscope with relative ease, so long as knee-chest position is maintained.

CASE REPORT OF MISINTERPRETATION

Our one grave error in interpretation is here presented:

The patient was admitted to Mt. Sinai Hospital on May 23, 1952. Her last menstrual period was April 8, 1952. Approximately one month before admission patient developed pains of a crampy nature in both lower quadrants. These radiated down the thighs. After spotting for two days an apparently normal period had started on May 10th. Two days after cessation of flow, spotting recurred and has continued to admission. Pain was cramping in nature and irregularly present since the last week in April. Frog pregnancy test was negative on May 20, and Salmon-Geist-Salmon-Frank immature rat pregnancy test was slightly positive, reported the day after consultative culdoscopy was done on May 24, 1952.

At culdoscopy a corpus luteum of pregnancy was seen in the left ovary. A small trickle of black blood was issuing from the fimbriated end of the left tube. The uterus was slightly enlarged and congested. Impression was "uterine pregnancy, early, with threatened abortion." The left tube was seen throughout its length and was considered as normal. The patient was discharged the next day. Pregnancy test was definitely positive one week later.

On June 28, 1952, she was admitted for operation with an acute tubal abortion and intra-abdominal hemorrhage. At operation, a 13 mm. fetus was found, aborted from the left tube, lying free in the pelvis in a pool of fresh blood and clots. Complete convalescence was further delayed by severe pelvic phlebitis.

SUMMARY AND CONCLUSION

A brief description of the culdoscope is presented with practical hints in its use. The only patient with serious error in interpretation of the visual findings is reported. However, we do believe that culdoscopy is an invaluable adjunct to the diagnosis of gynecologic disease. Its usefulness far outweighs its potential dangers.

Idiopathic Hypoprothrombinemia

Hypoprothrombinemia by definition means a deficiency of the prothrombin content of the blood, or an increase of the prothrombin time. The artificial means of creating hypoprothrombinemia is familiar, through the use of dicumarol,® and it is not surprising if the prothrombin time is found to be prolonged in hepatic disease. However, hypoprothrombinemia, of unexplained origin, remains an uncommon entity.

The first recorded case of idiopathic hypoprothrombinemia was reported in 1941. Since that time there have been 20 additional cases reported.—R. A. Desjardins, M. D., and K. E. Droulard, M. D., Lafayette, Ind.; *J. Indiana State M. A.*, 45:1153, November, 1952.

The Carotid Sinus Reflex

The attacks of unconsciousness, muscular twitchings and generalized convulsions which were first described by Morgagni, Adams, and Stokes, have until recent years been considered to be due always to ventricular asystole resulting from heart block. However, in 1941, Parkinson, Papp, and Evans found only 55 per cent of reviewed cases demonstrated this electrocardiographic abnormality, the remainder being due to ventricular tachycardia, ventricular fibrillation, or combinations of these with ventricular asystole. Schnur, Scott and Sanceta, and others have substantiated this observation.—Dan L. Urschel, M. D., Mentone, and Kenneth K. Kraning, M. D., Kewanna, Ind., *J. Indiana State M. A.*, 46:111, February, 1953.

Amyloidosis, Secondary to Syphilis

C. S. KELLOGG, M. D.

AMYLOIDOSIS, a type of hyalin degeneration, may occur as either a primary or a secondary condition. Secondary amyloidosis usually accompanies chronic suppurative diseases and chronic tuberculosis. However, it may accompany such non-suppurative diseases as leprosy, tumors, chronic nephritis, hepatic cirrhosis, syphilis, and infrequently is secondary to other diseases.[1]

Rarely are there cases of amyloidosis secondary to syphilis, and even more rarely are these cases reported. In a Mayo Clinic study[2] covering the period from 1921 to 1946 there were only 30 cases of secondary amyloidosis reported and only one of these was associated with syphilis. The latter case was not discussed.

CASE REPORT

Mrs. ....., a forty year old, white female, was first seen in our office on November 28, 1951, when she complained of upper abdominal pains, anorexia, abdominal distention and meno- and metrorrhagia. The symptoms referable to the gastrointestinal tract had been present for at least three months and had been getting steadily more severe. The meno- and metrorrhagia had been apparent for the past six months.

History: About the first of September 1951, the patient had become aware that she was losing weight and becoming anorexic. Gaseous distention followed the ingestion of nearly any kind of food. She noted a constant gnawing and burning in her stomach. These symptoms were not relieved by food or alkali. She consulted her family physician who sent her to another hospital for gastrointestinal x-ray studies. These were reported as showing no ulcer or other significant pathology.

Her doctor placed her on a bland diet and gave her belladonna and phenobarbital before meals. But, after ten weeks on this regimen with no improvement, she came to us for advice and reevaluation.

Past history revealed that in 1943 she had a 4 plus Wassermann reaction and had received apparently adequate mapharsen® and bismuth therapy. No penicillin had been given to her at that time. Her last blood test was also reported as 4 plus.

Her periods were always regular until the past six months when she began to flow every 15 days and the flow continued for five to seven days. There had been no spotting during the intermenstrual period. The patient had been pregnant on three occasions (1942, 1943, and 1949). All of these pregnancies ended in miscarriages before the fifth gestational month.

Physical examination revealed a well developed and well nourished forty year old woman, appearing ill and complaining of severe upper abdominal pain and burning. The skin was warm and dry with a definite icteric tint, but there were no areas of purpura or petechia. The temperature was 100, pulse 65, respirations 18, and blood pressure was 130/76-74.

The scleras of the eyes had a definite icteric tint and the right eye showed an anterior synechia of the iris due to trauma during childhood.

The abdomen was distended and there was a huge mass filling the upper part of the abdomen and extending to three fingerbreadths below the umbilicus. The mass appeared to cross the midline but the part on the left side of the abdomen was a little smaller than that on the right side. The mass was firm, smooth, and tender to palpation. It was felt that this mass represented the liver and spleen, both markedly enlarged. The rest of the physical examination was not remarkable.

Hospital Admission: With these findings, a presumptive diagnosis of chronic myelogenous leukemia was made and the patient was admitted to Toledo Hospital for blood and other confirmatory studies.

Laboratory Findings: Admission laboratory work revealed a red blood count of 5,300,000; hemoglobin 16.5 gm. (104 per cent of normal); white blood count 9,100 with 51 segmented polymorphonuclear neutrophile leukocytes, 43 lymphocytes and 6 monocytes. Alkaline phosphatase was 3.4 Bodanski units; total serum proteins 7.10 gm. per 100 cc. with albumin 4.21 gm. and globulin 2.89 gm. per 100 cc.; A/G ratio was 1.5/1; and the icterus index was 11 units. The platelet count was 158,000; the red blood cell fragility test revealed initial lysis 0.40-0.32 and complete lysis 0.30-0.28. The urine was essentially normal.

Reaction to the blood Kline test was positive as was the Wassermann (31000). A bone marrow smear was done but this was not of aid in diagnosis of this case.

A flat x-ray of the abdomen revealed a large liver but no definite splenic enlargement.

At this point the diagnosis was changed from chronic myelogenous leukemia to hepatomegaly, cause unknown.

A Congo red test was next done by injecting 0.2 cc. of a 0.6 per cent solution of Congo red per 1 kilogram of body weight, intravenously and the results showed 78 per cent disappearance from the blood. A presumptive diagnosis of amyloidosis was made at this time.

Operation: A surgical consultation was asked and obtained, and it was decided to explore the patient's abdomen and to obtain a biopsy specimen of the affected organs. Dr. F. P. Osgood opened the abdomen and noted that the liver was a huge blue organ. It filled nearly the entire abdominal cavity. It was velvety-soft without any gross nodularity. Both lobes of the liver were

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Submitted November 28, 1952.

markedly enlarged and the left lobe was the mass that filled the left side of the abdomen. The spleen was slightly enlarged as were both kidneys.

Pathologic Diagnosis: A wedge-shaped piece of the liver was removed from the anterior margin and was sent to the laboratory for diagnosis. The pathological report was "amyloidosis of the liver showing patchy fibrosis, suggestive of lues."

Immediately following the operation, the patient sank into deep shock and this condition continued for about four hours. After 1000 cc. of blood and adequate intravenous fluids her condition improved. She was discharged from the Toledo Hospital on the seventh postoperative day.

Clinical Course: Following discharge from the hospital the patient was treated with 600,000 units of crystaline penicillin twice daily until a total of 9 million units were given. After a rest of six weeks, this program was again repeated. In conjunction with this program she was given general supportive measures and bed rest. Choline chloride, methionine, multiple vitamin capsules and a high protein, high carbohydrate and low fat diet were parts of the regimen.

In spite of these measures the patient led a gradual downhill course and soon became very edematous. She rapidly developed ascites and before a paracentesis could be performed the patient expired on June 21, 1952.

COMMENT

Since this condition occurs so infrequently, a definite regimen of treatment has not been established by precedent. It therefore becomes a problem of vigorous treatment of the primary condition in the hope that the extension of the associated amyloidosis may not progress.

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Operations for Duodenal Ulcer

The physiological basis for operations for duodenal ulcer is to reduce the digestive power of the gastric juice to a point where peptic ulcer can no longer occur. The digestive power of the gastric juice is related to its content of hydrochloric acid and pepsin. Ideally, an operation should modify the digestive properties of the gastric contents sufficiently to give complete and permanent protection against further ulceration. In addition to the digestive properties of the gastric contents another factor, the capacity of the mucosa to resist ulceration, is also of unquestioned importance in the development of duodenal ulcer. This must vary greatly from patient to patient. As yet, no method has been devised for measuring this factor in each case. Consequently, it is necessary to modify the acid peptic factors in every case sufficiently to give protection to those patients having the lowest resistance to ulceration.—Reginald H. Smithwick, M. D., Boston; *Rhode Island M. J.*, 36:77, February, 1953.

KEEPING UP WITH MEDICINE

• OUR usual treatment of hyperacidity fails to take into consideration the physiologic processes of neutralization.

* * *

• FOLIC ACID is of no value in cases of granulocytosis where the condition is due to ingested drugs but of great value in those rare cases where it is due to a deficiency of folic acid.

* * *

• THE DEATH RATE from accidents is higher among the obese as is suicide showing that to be "fat" and "jolly" are not synonymous.

* * *

• PATIENTS with "nephrosis" should be given a diet high in protein.

* * *

• IN THOSE cases of acne rosacea where alcohol need not be forbidden entirely, because of liver damage dilute drinks such as highballs, Tom Collins and the like can safely be used, whereas the concentrated drinks may cause trouble.

* * *

• ON THE LIPS the common sensitizers are: lipstick, toothpastes, lozenges, cosmetics, and in children, foods. In the mouth: dentifrices, mouthwashes, gargles, breath purifiers, teeth whiteners, dentures, metal fillings, local anesthestics, chewing gum, chocolate candy and foods.

* * *

• AN AUTHORITY recently observed that in his experience cortisone and ACTH taken internally may be habit forming and the desire for the drug may be every bit as strong as for a narcotic.

* * *

• THE SUGGESTION has recently been made that a deficiency of hyaluronidase may be a factor in the etiology of generalized sclero derma.

* * *

• ALMOST all if not all patients with venous stasis and especially those with ulcers have epidermophytosis. This infestation is often responsible for the intractable phase of the ulcer. Good foot hygiene then is always the place to begin the management of stasis ulcers.

* * *

• A SINGLE test of gastric secretion for response to histamine is helpful but never conclusive in the individual case.

* * *

• REPORTS are coming in of the success of sulfonamide prophylaxis in reducing the recurrences in rheumatic fever.

* * *

• THE COMPOUNDS associated with Chronic Respiratory Berylliosis are beryllium oxide and zinc beryllium manganese silicates. Prescription for rest must be given in detail. Each patient presents an individual problem.—J. F.

Psychiatric Practice

JACK M. KENYON, M.D.

PSYCHIATRY, as a branch of medicine, is in the process of being accepted on the same basis as other medical specialties. That this acceptance is incomplete by the medical profession is indicated by remarks to emotionally disturbed patients by their physicians, such as: "There is nothing wrong with you, just pull yourself together." "You better get hold of yourself or you will end up in a mental hospital."

However well intentioned, these remarks are not very helpful to the patient. Friends of the emotionally disturbed patient are sometimes equally confusing in their advice as: "You are not crazy, your memory is good." "You are not sick, you just think you are." "If you think you are crazy, that is a sure sign you are all right."

TWO HUNDRED CASES STUDIED

Some patients, and even some medical advisers, apparently believe that a psychiatric interview means prompt admission to a State Hospital, shock treatment, force of some nature, or labelling as being mentally ill. It is with these conceptions of psychiatric practice in mind that a brief review of 200 consecutive patients seen in 1952 is offered.

Diagnosis as follows:

Psychotic	56
Neurotic	103
Childhood and Adult Maladjustments	29
Homosexuals	3
Mentally defective	2
Undiagnosed	7

These patients were office patients, except for two disturbed patients who were seen in the hospital. The undiagnosed cases were due to failure to return to complete investigation.

Of the 200 patients, 59 were group referred, and 141 were referrals from outside the group direct to the psychiatrist.

PSYCHOSES

The psychotic patients included the following groups:

Organic psychoses		9
Functional psychoses:	First illness	31
	Recurrence	16
		56

Further classification of this group included:

Recovered	27
Admitted to psychiatric hospital (Private and State)	12
Unchanged	17
	56

Submitted January 20, 1953.

The Author

● **Dr. Kenyon, Toledo, Ohio, is a member of the Toledo Mental Hygiene Council; on staff, Flower and Toledo Hospitals.**

Psychotic patients give better cooperation when they realize that the psychiatrist is more concerned with keeping patients out of psychiatric hospitals when possible, than arranging their admission. A number of patients, who have previously been ill, realizing that they are developing premonitory symptoms voluntarily seek help.

NEUROSES

The majority of the psychiatrist's practice consists of patients with neuroses. Many come hopeful of a cure with medication. Psychotherapy is the treatment of choice, yet too many individuals are still unprepared for this form of therapy. There is a popular notion that if the neurosis is not physical then they should be able to shrug it off whether it is a disabling compulsion, a long standing phobia, or an acute anxiety state.

These individuals have usually been recognized as functional problems by the family doctor. There is too often undue delay between the appearance of symptoms, recognition of a functional illness, and the first visit to the psychiatrist. As with cancer, heart disease, or diabetes, in psychiatric problems the earlier specific treatment is instituted, the better the response to it.

It is sometimes a lecture, a newspaper article, or magazine article which may send a patient to a psychiatrist. With marital problems it may be the lawyer, who was consulted for divorce, who referred the patient, although the problem had been discussed with the family doctor. It is not recognition of a functional condition that is delayed as much as instituting specific treatment promptly in those conditions warranting it.

An occasional person who tends to conceal a specific phobia may pass through repeated examinations without the phobia being detected. An example of this was a 30 year old mother who came with the fear of being alone. Three years previously she was treated for a spastic colon. Then a year previously, she had a fear of heart disease but did not discuss it with her physician, although she visited him for a general examination. Now the fear of being home alone or venturing out alone could not be concealed. Psychiatric treatment could have been instituted

three years previously if the patient had been frank with her physician.

Another patient with diabetes had a fear of leaving her home. She was intelligent enough to recognize the risks of an uncontrolled diabetes. Eventually she suffered diabetic gangrene of her right leg and an amputation was performed. A year later she sought psychiatric treatment, with good response to treatment. Earlier treatment would have permitted diabetic control and probably have avoided the amputation.

PRIMARY BEHAVIOR PROBLEMS

Childhood and adult maladjustments refer to primary behavior problems in children and their equivalents in adult life. This group was the least ill, responded fairly promptly to psychotherapy.

The seven patients who were undiagnosed are for the most part individuals who came for interview for other reasons than medical help. One man, an alcoholic, came once at his wife's request but refused to return since he had carried out his promise. The interview was unsatisfactory because information secured was insufficient to establish a satisfactory diagnosis.

SUMMARY

It is indicated that psychiatry is not fully accepted as a branch of medicine; that this lack of acceptance delays treatment. A brief summary of 200 consecutive patients is offered to indicate the type of patients seen in private practice, that these are largely non psychotic, that psychiatric referral does not usually indicate the patient is psychotic.

Further education as to the nature of psychiatric therapies will reduce the delays in treatment and permit earlier specific treatment.

The Low Salt Syndrome

In chronic congestive heart failure, although the total body sodium is increased, the serum sodium may be decreased. This must be sharply differentiated from the acute congestive failure seen, for example, following infarction of the left ventricle where the extra lung volume results from transferral of fluid from the periphery by a competent right ventricle, and where, obviously, there is no time for electrolyte disturbance to develop.

Excess sweating produces the well-known "Stoker's Cramps" and many men working in extreme temperatures at Boulder Dam died as a result of the continual loss of electrolyte, replaced only by drinking water. One of the forms of collapse due to prolonged exposure to the sun is due to this same mechanism. Replacement of electrolyte losses with enteric coated sodium chloride tablets is satisfactory prophylaxis.—Charles M. Ballentine, M. D., Atlanta; *J. M. A. Georgia*, 42:84, February, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Seltzer—This term which is now generally applied to any carbonated water, originally referred to a natural mineral water containing free carbonic acid which was obtained from a spring at Selters, a village in Hesse-Nassau, Germany.

Science—The word science means knowing and comes from the Latin word "scio," I know.

Tibia—This is a Latin word of ancient usage designating the shinbone and the term was also applied to a pipe or flute. There is some question as to whether the bone was named from the pipe or flute or whether the flute was named after the bone. However, in ancient times, primitive flutes and musical pipes were commonly made from bones, reeds and horns. The shinbones or tibias of birds were commonly used for this purpose and hence it is believed that the flute was named after the bone from which it was fashioned.

Pyrosis—Commonly known as "heartburn" this stomach condition is characterized by a burning sensation and eructations of an acid fluid. The name is descriptive and is derived from the Greek word "purosis" meaning a burning, which in turn comes from the Greek word "pur" or fire.

Bleb—An imitative word simulating the sound made by a drop of water. Hence by extension it came to mean a drop of water, and then a small blister or vesicle filled with a drop of water or water-like exudate.

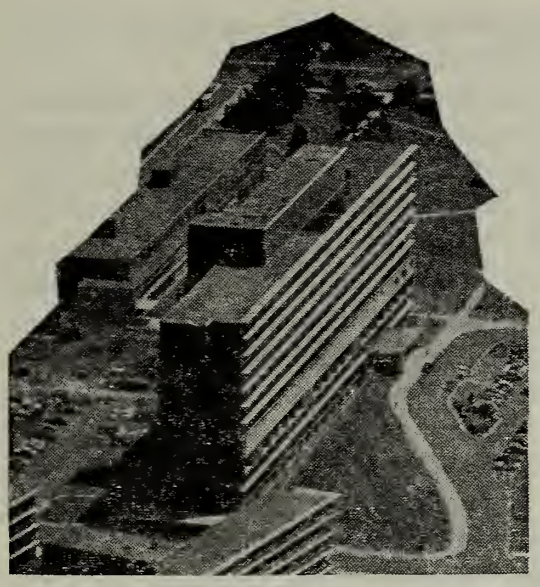
Test—Our word test is derived from the Latin word "testum" meaning a pot or earthen vessel. Because the Alchemists of old tried or "tested" things by heating them in a pot or "testum," the word "test" came by transference to be applied to the procedure. Chaucer used the word in 14th Century English.

Baby—The words, babe and baby, both originate from the imitation of the "ba-ba" babbling sounds of an infant.

Tenaculum—A Latin term literally meaning a holder which is derived from the Latin word "teneo" meaning to hold. This descriptive name has long been applied to a slender hook-shaped instrument with a long handle which is used for seizing and holding parts during surgical operations.

Navicular Bone—This is the largest bone of the proximal row of the carpus or wrist bones. It is so-named because of its fancied resemblance to a boat. The name is derived from the Latin word "navicula" or little ship, and is the diminutive of "navis" or ship.

—Harry Wain, M. D., Mansfield, Ohio.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Robert Ritterhoff, M. D., President

Presented by John Prior, M. D., and Abraham Towbin, M. D. Edited by E. von Haam, M. D.

PRESENTATION OF CASE

THE patient, a 50 year old white man, had always been well except for a peptic ulcer ten years ago. Three weeks before admission he developed severe poison ivy dermatitis over his hands, arms and legs. He was treated with a preparation containing phenol and tannic acid. The lesions became secondarily infected and he was treated with penicillin and was later given a total of 7 Gm. of sulfa drug beginning four days before admission. Three days before admission his temperature suddenly rose to 104, his urinary output began to fall, and the urine became dark. He developed backache, severe headache and vomiting and became lethargic. He was admitted to University Hospital.

Physical Examination: Temperature 99, pulse 82, respirations 24, blood pressure 120/70. Examination disclosed a well developed, well nourished white man lying quietly in bed. There were dry scaly lesions on his hands, arms and legs. Examination of the eyes, ears, nose and throat revealed no abnormalities. The lips were dry and cracked. Respirations were regular and equal; the lungs were normal to percussion and auscultation. The heart was not enlarged, the rhythm was regular, and no murmurs were heard. There was slight costocertebral angle tenderness. The kidneys, spleen and liver were not felt. Rectal examination revealed a slightly enlarged, soft prostate gland. The reflexes were equal and slightly hyperactive.

Laboratory Data: The admission red blood cell count was 3.64 million with 10.0 Gm. of hemoglobin; the white blood cell count was 10,550 with 81 per cent polymorphonuclear neutrophil leukocytes. The red count was maintained by transfusions of whole blood but terminally was 2.36 mil. with 6.5 Gm. of hemoglobin. The admission urine was "loaded" with red blood cells and continued to show large numbers of red and white cells; the specific gravity varied between 1.005 and 1.015. The blood urea nitrogen on admission was 50 mg.; this rose to 91 mg. by the fourteenth day and by the twenty-first day had reached a maximum of 115 mg. It gradually fell over the next two weeks to 31 mg. The blood sodium was normal; potassium reached 25.6 mg. four days after admission but subsequently fell to normal levels. The electrocardiogram was normal except on one occasion, after digitalis, when it showed a first degree heart block. Blood sulfa level determination shortly after admission showed 1.9 mg.

Hospital Course: For several days the urinary output did not exceed 150 cc.; it gradually rose until by the twelfth hospital day it averaged about 1000 cc. daily and subsequently reached about 2000 cc. daily. His blood chemical balance was maintained with intravenous fluids. Cystoscopy was performed on two occasions.

The patient showed slow general improvement over a one-month period, then suddenly became unconscious, cyanotic, and exhibited spastic paralysis of all extremities, a Babinski sign on the right, and depressed respirations. He responded to analeptics. The blood pressure rose to 170/100 and lumbar punctures revealed elevated spinal fluid pressure (250 mm.). Repeated taps were done for a 24 hour period; the spinal fluid was clear and the patient regained consciousness. Three days later he again became unconscious and was pronounced dead shortly thereafter.

CLINICAL DISCUSSION

DR. JOHN PRIOR: The problem here seems to me to be one of uremia and of the differential diagnosis of the causes of uremia; and secondly, the determination of the cause of this patient's

rather sudden death after he had been apparently improving from his acute renal insufficiency. One of the causes that must always be considered as a cause of uremia in a man of this age is prostatic obstruction or possibly other mechanical causes of obstruction. However, the history does not suggest any evidence of previous difficulty such as dribbling, hesitancy, poor stream, dysuria, nocturia or frequency. In addition cystoscopy was performed on this man on two occasions and no evidence of obstruction was demonstrated.

Another possibility that is frequently overlooked in the differential diagnosis of uremia is congenital polycystic disease of the kidneys. At times there is a sensation for months or years of dragging or heaviness in the abdomen on one side or the other. In the majority of cases the enlarged kidney is palpable.

Hypertension is reported to be present in about 70 per cent of the patients, and the eyegrounds will show evidence of the hypertension with a A-V nicking and arteriolar narrowing in 35 to 40 per cent. Hematuria, albuminuria, dysuria, and an increasing number of white cells in the urine are relatively as frequent as the hypertension. Renal insufficiency may develop but is usually insidious in onset.

AMYLOIDOSIS

Another possibility is, of course, amyloidosis. It occurs as a primary form which is very rare and involves the myocardium and some of the mesodermal structures. The secondary form tends to occur after suppuration or tuberculosis of the lungs. It has been reported following chronic suppuration elsewhere in the body. Most commonly it results in a very slowly developing nephrosis with considerable albuminuria. A Congo red test which may be helpful was not done. The usual etiologic factors were not present in this patient and amyloidosis would not account for the precipitous onset of acute renal insufficiency.

Chronic glomerulonephritis in its terminal state is another possibility which might account for the uremia. This does not seem likely to me because we have here a man who has been in apparently good health and has shown no evidence of hypertension or anemia until shortly before death. The onset of his illness seems also a little late in life for the first manifestation of chronic glomerulonephritis, which is usually not as precipitous in onset as we have here. In addition there were no demonstrable changes in the eyegrounds suggestive of recent or past renal involvement. There should also be alteration of the proteins with reversal of the albumin-globulin ratio and lowered total proteins. It is of course possible that an acute exacerbation of a dormant renal disease be precipitated by streptococcal infections. However, one would expect to find some antecedent history, physical findings, or laboratory data suggestive of latent glomerulonephritis.

Another possibility is upper nephron nephrosis involving the upper portion of the renal tubules such as observed in heavy metal intoxication. We have no such history in this case.

Still another possibility which must always be considered is pyelonephritis. I would expect that if a pyelonephritis had been present for a long period of time we might find evidence of hypertension, arteriolar spasms, hemorrhage and exudate in the eyegrounds as well as albuminuria and numerous white cells in the urine. Instead his sediment showed large numbers of red blood cells, pigment casts, and red blood cell casts. Although much albumin was present, only occasional white blood cells were reported on admission. The onset of his illness was very sudden. It was associated with fever and chills that might suggest the possibility of an infectious process. I think we are all too prone to jump to the conclusion that if we have fever it must be on the basis of an infectious origin. There are many known causes other than infection which might be responsible for the development of fever. In addition, there has not been the usual story of frequency, dysuria, nocturia, that often goes with acute pyelonephritis.

LOWER NEPHRON NEPHROSIS

I would believe the best diagnostic possibility in this case is a lower nephron nephrosis. We have an antecedent history of sulfonamide administration—7 grams over a period of four days, before which time his renal function was apparently perfectly normal. In the development of a lower nephron nephrosis three etiologic factors are most commonly encountered although there are others. Those three are: (1) trauma to muscles such as crushing injuries associated with severe injuries; (2) blood transfusions; and (3) the administration of sulfonamides.

Lower nephron nephrosis usually develops rapidly after any of these causes. First the patients usually develop headache and backache. The backache is often so severe that some of these patients have laparotomies for possible intra-abdominal injuries. Vomiting is another common symptom. The specific gravity of the urine tends to remain very close to 1.010; the urine is often of a very dark brown or wine color, or grossly bloody, and the sediment contains a great many pigmented casts. In addition hemoglobin or myohemoglobin may be demonstrated chemically.

As time goes on there is usually a very marked albuminuria. A very high degree of urinary acidity is present and the *p*H tends to range between 4.5 and 6. Most of the urinary *p*H values reported in this patient ranged in the neighborhood of 5.0 to 5.5. Soon the output becomes very small, perhaps only a few cubic centi-

meters per day. The blood urea nitrogen rises and in time reaches very high levels, sometimes over 200 and even over 300 mg. per 100 cc. The carbon dioxide combining power of the blood usually diminishes as a manifestation of the acidosis. The serum calcium drops and there tends to be a rise of the serum potassium and phosphorus.

If the nephrosis is very severe, the patients die as a result of uremia; or if they can be kept alive during their critical stage of oliguria, about 10 to 14 days as an average, they may recover. However, there have been a number of patients who have lived for as long as 30 to 50 days who still succumbed to lower nephron nephrosis. Edema, especially pulmonary, develops very frequently and this may well be due to the fact that we are entirely too vigorous in treatment of these patients with parenteral fluids. Edema may be an important phase of the disease and may be responsible for death. Uremia, as you know, tends to involve the vessels, so that hemorrhages are not uncommon anywhere in the body and hemorrhage may also be the cause of the exitus.

Based on the symptoms and the course of his illness, I would suggest that this man had a lower nephron nephrosis. Along towards about the tenth or twelfth day he began to have some diuresis and subsequently began to show some slow improvement in his blood chemistry. However, he did not improve greatly. It was necessary to withhold parenteral fluids for a while to control the edema which was relatively marked. A definite pericardial friction rub was noticed during the last few days of his life.

Although there was a definite improvement in his blood chemistry and an increase in urine output throughout the latter course of his illness, I think it is possible that he may have had terminal potassium intoxication. We also have evidence of spastic paralysis which in all probability was definitely a result of hemorrhage into his brain. It is possible he died as a result of repeated hemorrhage into the brain.

In some instances patients with lower nephron nephrosis may have diuresis and improvement in the blood chemical values and then have relapse at times with renal insufficiency and potassium intoxication. This aspect may be followed by serial electrocardiograms, in which the first changes may be alteration of the T waves and heart block may develop. In addition to hemorrhage and potassium intoxication, diffuse vascular damage may have been present as evidenced by the elevated blood pressure.

CLINICAL DIAGNOSIS

1. Lower nephron nephrosis.
2. Brain hemorrhage.

PATHOLOGICAL DIAGNOSIS

1. Nephrosis of the kidneys (sulfadiazine idiosyncrasy).
2. Generalized arterial necrosis and perivascular inflammation (sulfadiazine idiosyncrasy).
3. Organizing pneumonia.
4. Arteriosclerotic heart disease with old thrombosis of right coronary artery; slight myocardial hypertrophy.
5. Cortical adenoma of adrenal.
6. Glandular hypertrophy of prostate.

PATHOLOGICAL DISCUSSION

DR. ABRAHAM TOWBIN: This proved to be a case of death due to sensitivity to a drug. The exact pathogenesis in cases such as this is not always entirely clear. In this instance, death was not due to sulfonamide precipitate in the kidney as is seen in some cases in which this therapy is used. This man had a background of allergy; he had recently had poison ivy dermatitis; he was certainly a candidate for a sensitivity reaction to a drug.

The kidney was swollen and weighed 300 grams. It had the classical appearance of the "flea-bitten" kidney; the numerous fine hemorrhages on the external surface are commonly due to focal embolic glomerulitis as occurs in subacute bacterial endocarditis; it is also seen in vascular lesions such as the necrotizing arteriolitis of malignant nephrosclerosis. Since this man had no gross findings of an endocarditis, attention is directed to the vascular elements.

MICROSCOPIC STUDY

The microscopic section of the kidney showed a bizarre mixture of lesions involving all of the elements of the organ—tubular, glomerular, and particularly vascular. The simple physical clogging of the ducts by crystalline precipitate is not present in this case. The tubular lesion is for the most part in the nature of a chemical nephrosis similar to that seen in the bichloride of mercury kidney. In the medullary zones the tubules contain pigment casts as is seen in lower nephron nephrosis. This section also shows a severe glomerular lesion; there is rich proliferation of the glomerular capsule with formation of crescents as characteristically appear in subacute glomerulonephritis.

Although the tubular and glomerular lesions are prominent, this kidney presents a severe vascular lesion, an arteritis. The small caliber arteries are implicated, and all of the layers of the vessels are involved. These microscopic vascular lesions, with perivascular hemorrhage, account for the "flea-bitten" appearance seen grossly. This vasculitis is present not only in the kidney but in the liver, pancreas, and most of the other organs. It probably represents the primal lesion instigated by the drug sensitivity phenomenon.

This lesion is similar to that seen in periarteritis nodosa and disseminated lupus; it differs

from the collagenous diseases in that the fibrinoid changes are not prominent; also splenic changes and the wireloop lesion of the glomeruli are not evident. Vascular lesions similar to those in this case have been produced by Rich in his experiments in allergy with animals.

The microscopic sections of lung show the picture of bilateral bronchopneumonia in the stage of organization. Most of the exudate was replaced by fibrous tissue, and it is felt that this process represented a lesion which occurred in the early days of his disease, probably as a consequence of his poison ivy dermatitis. In spite of the fact that the right coronary artery was partly occluded by a thrombus, sections of myocardium showed only little evidence of myocardial damage. Unfortunately, permission for postmortem examination of the head was not granted and for this reason the brain could not be examined.

In summary we may state that death of the patient was primarily due to a sensitivity reaction to sulfonamide manifested by generalized necrotizing arteriolitis and the development of severe nephrotoxic lesions. He died in a state of uremia with cerebral manifestations.

GENERAL DISCUSSION

DR. PRIOR: It is your opinion then that all of the changes reported grossly and microscopically were the result of a sensitivity reaction to the sulfonamides which he received?

DR. TOWBIN: Yes, the vascular and nephrotoxic changes are probably direct manifestations of the sensitivity reaction.

DR. PRIOR: The maintenance of these patients requires very careful chemical study and I am sure that most of you are well aware of the fact. With this type of disease, which we believe in all probability is a reversible condition, the best thing we have to offer is the artificial kidney. Of course, it is not available here but we hope we may have it in the not too distant future.

It is very essential to follow the potassium, calcium, and phosphorous levels. In Boston, they are following these people with several electrocardiograms and using that as a guide for potassium intoxication. When changes appear, they feel an effort should be made to diminish potassium in the blood. The calcium and chlorides, which often are low, should be administered to these patients when necessary. Fluid should be very carefully controlled so as not to "overload" them. The objective of administration of fluids is to simply replace the loss occurring each day.

There is a diet that has been suggested to maintain their nutrition through the course of their illness—a relatively simple diet of 150 grams of butter and 200 grams of sugar. This provides in the neighborhood of 2,000 calories daily, is low in potassium and phosphorus, particularly the former. It is believed by most people that these patients should be maintained on relatively large amounts of carbohydrates and fats, with very little or no protein. Where no protein is given, protein catabolism gradually decreases, so there is less formation of nitrogenous products. Also it tends to diminish the transfer of intracellular potassium into the extracellular system.

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Effect of Ionizing Radiation On Trichina Larvae

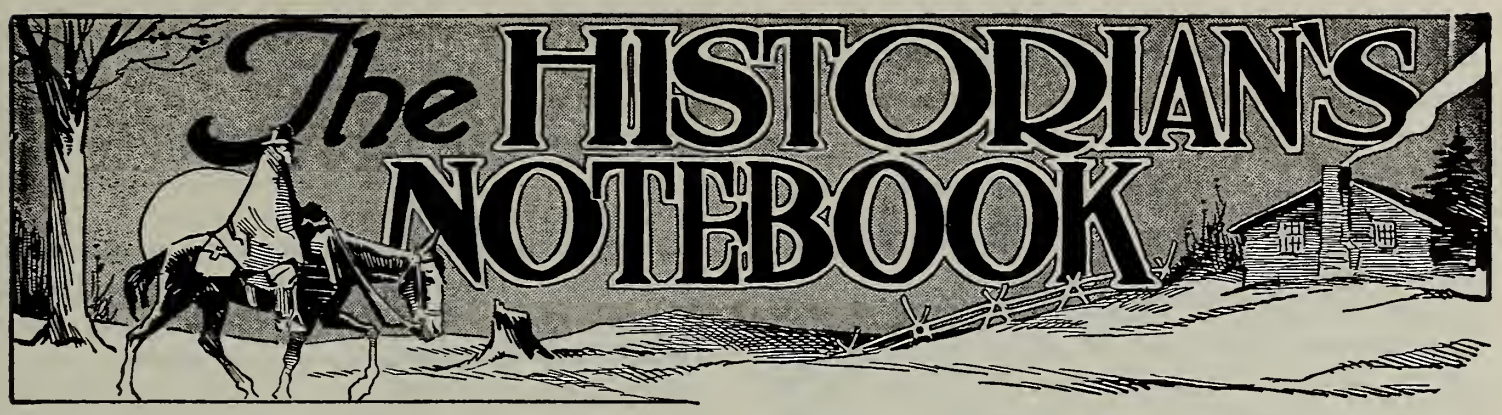
Ionizing radiation, such as x-rays, gamma rays and high energy electrons, has been shown to be effective in killing or interfering with normal development of living material. During the past year the effect of radiation on the life cycle of the causative agent of trichinosis *(Trichinella spiralis)* has been studied. From these data, it was hoped to develop a new approach to the control of trichinosis.

It has been found that about 1,000,000 roentgens of 200 KV x-rays are necessary to kill all trichina larvae irradiated *in vitro*. The killing dose for Cobalt-60 gamma rays (1.17 and 1.31 Mev) was found to be about the same.

However, the life cycle of trichina requires that the ingested larvae grow to maturity in the host and then reproduce. It has been found that radiation doses much smaller than killing doses are sufficient to inhibit maturation and that even smaller doses will sterilize the female trichinae and prevent reproduction. With Cobalt-60 gamma rays, about 10,000 roentgens will sterilize all the female larvae in rat muscle as determined by microscopic examination of the adult female forms recovered from the intestinal tract at 6 days and larval forms recovered from the muscle of the test animals at 30 days. Somewhat lower levels of 200 KV x-rays are equally effective.

Because of the great penetrating power of Cobalt-60 radiation, it is believed that large sections of meat such as hog carcasses could, under suitable conditions, be irradiated as a whole, thus providing a direct method of breaking the trichina cycle.—HENRY J. GOMBERG, PH. D., assistant director, Michigan-Memorial Phoenix Project and research associate, Atomic Energy Commission Laboratory, University of Michigan, Ann Arbor, Mich., and S. E. GOULD, M. D., pathologist, Wayne County General Hospital, Eloise, Mich., and research associate, Atomic Energy Commission Laboratory, University of Michigan, Ann Arbor, Mich.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.



The Blue Soldier—His Health—His Physicians

CLARK P. PRITCHETT, M. D.

PART I

"I AM not very well and I do not think I ever will be again," wrote a New Yorker in December, 1861, a few weeks after his arrival in Dixie. A year later an Ohioan serving in Tennessee informed his parents: "Christopher Dimick is ded, that makes 3 of the Dover boys that has died out of 42 and one killed, that is about the way, there is more dies by sickness then gets killed."

An Ohioan, plagued by mud and mosquitoes near Vicksburg and alarmed by the tide of sickness, in March, 1863, wrote in plaintive wrath: "The doctors are no a conte—hell will bea filde with doctors and officers when this war is over." Another Ohioan in May, 1864, reported a recent experience near Chattanooga: "The surgeon insisted on sending me to the hospital for treatment. I insisted on taking the field and prevailed—thinking I had better die by rebel bullets than Union Quackery."

No wonder "Billy Yank," the Soldier in Blue, was often a blue soldier.

THE STATE OF AFFAIRS AT ONSET OF THE WAR OF 1861

The great war of the Century between the Napoleonic Wars and the first World War, was the Civil War. In that war some 300,000 Union soldiers lost their lives. Confederate attacks account for only a third of these deaths, disease for the rest. There were 400,000 cases of wounds and injuries and almost 6,000,000 cases of sickness. Startling as these figures are, they nevertheless represent a great improvement over those of the Mexican War, when ten men had died of disease for every man killed by the enemy.

Behind the sickness and mortality statistics of the Civil War lie ignorance, stupidity, inefficiency and jealousy. But behind them also, as the contrast with the earlier war suggests, are to be seen earnestness, cooperative spirit, and great strides in scientific knowledge, which a later generation has all but forgotten.

The Author

● **Dr. Pritchett, Columbus, is assistant clinical professor, the Ohio State University College of Medicine.**

UNREADINESS

The Army Medical Department entered the war unprepared. Its chief, Colonel Thomas Lawson, a veteran of the War of 1812, was over 80 years of age. Seniority had brought him into office during the administration of John Quincy Adams and in the absence of any retirement law he had stayed on and on, concerned principally with pruning the budget. He considered the purchase of medical books an extravagance and is reported to have flown into a rage on learning that one army post owned two sets of surgical instruments.

Next to economy Colonel Lawson was most concerned over the military status of his corps. He is credited with having secured the passage of the act of 1847 which conferred army rank upon the surgeons. They had previously been called simply "doctor" now they might be greeted as "captain" and "major." His subordinates thought him a martinet; and he would keep a man at a lonely post on the plains for as long as ten years before allowing a sixty-day leave of absence.

The long Lawson regime may have been resented but its habits and ideas had seeped through the whole medical corps. At any rate

Read before the January, 1953, meeting of the Kit Kat Club, Columbus, Ohio.

the efforts of the Sanitary Commission, organized outside the Army, which sought to give advice and help were, in most cases, ignored or resisted.

MEDICAL DEPARTMENT PERSONNEL

The Medical Department personnel seemed pitifully small when measured against the duties soon to fall upon it. Actually the medical staff, though under 1 per cent of the Army, was then considered large. In January, 1861, the United States Army numbered 16,000 soldiers. In the last year of peace it had averaged 13,531. Its medical staff was made up of the Surgeon General, 30 surgeons, and 83 assistant surgeons. Three surgeons and 21 assistant surgeons of Southern origin resigned to "go with their States," while five surgeons and eight assistant surgeons, whose homes were in seceded states, stayed on. Three assistant surgeons were dismissed for disloyalty. Consequently the corps began its war service with only 98 officers.

Headquarters consisted of the Surgeon General, two surgeons who acted as his "assistants," and two assistant surgeons whose work was mainly clerical. These, with the aid of only three clerks, administered the affairs of the bureau. However, the Quartermaster Corps had charge of the erection and equipment of military hospitals and the transportation of the sick and wounded, while the Subsistence Department had charge of supplies.

BUDGETS

Surgeon General Lawson's parsimony is shown in his appropriations. In 1860 the bureau lived on $90,000, of which $27,000 was paid for the services of civilian physicians serving in military hospitals under contract. In March, 1861, despite the imminence of war, Congress appropriated only $115,000. In all, $241,000 was made available before July 1, 1861, of which $194,000 was spent, mainly, on medical stores.

On these small budgets the department cared for a surprisingly large number of sick—30,300 cases in 1859-1860, or an average of two illnesses per man for the year. Mortality was light, only 138 deaths during the year, with tuberculosis, and gunshot wounds received in Indian fighting, as the major causes.

"GOING INTO THE ARMY"

The South's attack on Fort Sumter fell like a thunderclap on the country north of Dixie. True, there had been talk of war, especially since the secession of the cotton states and the organization of the Southern Confederacy, but agitators, consisting mainly of politicans, journalists, preachers, and reformers were relatively few. A substantial portion of the population still hoped for a peaceful solution of the sectional crisis even after "Jeff" Davis set up his rival government.

Fort Sumter changed all this. The flag had been affronted. Men wearing the American uniform had been forced by hostile fire to surrender a Federal fort and march out in acknowledged defeat.

The die was cast!

Lincoln's request for troops was in sense an anti-climax. The roar of cannon at Charleston, like the crash of bombs 80 years later at Pearl Harbor, was the country's call to arms.

During most of the war the raising of troops was a slow and painful process. But in the weeks following Fort Sumter the opposite was true. All over the country men rushed to arms with camp meeting fervor. Preachers catching the spirit of the hour proclaimed the gospel of patriotism from the pulpit. In Bath, Maine, the Episcopal rector was the first to enlist, and in Madison, Wisconsin, on the Sunday after Lincoln's call for troops the Reverend William Brisbane of the Baptist Church, a recent volunteer in a local company, preached his farewell sermon in his shiny new uniform.

Nowhere was the war spirit more rampant than in the class room. In Oxford, Ohio, Oyra J. Dodds, a senior in college, rose in the chapel and proposed organization of a University Rifle Company. Within a few minutes 160 students and local boys signed up for service in what was to become Company B, Twentieth Ohio Volunteers. Girls of the neighboring female college, not to be outdone set themselves to making red shirts, flannel underclothing, and a flag for the volunteers.

At Oberlin College a student wrote his brother, "War! and volunteers are the only topics of conversation or thought. The lessons today have been a mere form. I cannot study. I cannot sleep. I cannot work, and I don't know as I can write."

The problem of responsible authorities during this flood tide of patriotism was not to obtain men, but to hold volunteers to manageable numbers. Governor Dennison of Ohio, of whom Lincoln requested 13 regiments, wrote a week later that, "owing to an unavoidable confusion in the first hurry and enthusiasm of our people, a much larger force has already been mobilized. Indeed," he added, "without seriously repressing the ardor of the people I can hardly stop short of 20 regiments."

What a pity that the government did not accept and constitute as a national reserve this horde of men who in the spring of 1861 so eagerly sought service. More than a million recruits could have been had without difficulty then, but within a year volunteering had slowed down to a trickle.

MOTIVES FOR JOINING UNION ARMY

Why did the men in blue go to war? For what were they fighting? Immediate impulses

were varied. Prevailing excitement, the lure of far places and the desire for change were dominant factors in the enlistment of many. Countless numbers of men joined up because of the example of friends and associates.

The economic motive influenced many. It seems preposterous to us, that $13 a month, the pay of infantry privates during most of the war, should be an attraction. But the first months of the war were marked by depression, and unemployment recurred periodically until 1863. Too, bounties early became a part of the recruiting system, and these were steadily increased until early in 1864 a soldier was able to write: "I receive for re-enlisting nearly—eight hundred dollars. Which I shall devote to straightening things at home."

If soldier pay was low, so were wages in general, and army employment had a certainty and permanence rarely found in field and factory.

Financial inducement seems to have been especially cogent among the immigrants, about two million of whom had flocked to the north in the 1850's. Poverty, difficulties of employment, prior acquaintance with military life and a strong desire to acquire property combined with other influences to drive thousands of them into the army.

After resort to conscription the urge to avoid the stigma of forced service, plus the desire to obtain certain privileges allowed only volunteers, caused thousands to enlist. A Civil War historian (Arthur C. Cole, *The Era of the Civil War)* referring specifically to Ohio, characterized the desire to avoid the draft as "the great spur to enlistment."

Love of country and hatred of those who seemed bent on destroying its institutions impelled many to enlist, though often patriotism was indistinguishly blended with practical urges. Hence, original impulses of individuals ranged from material considerations and a mere craving for excitement to profound idealism and hatred of traitors. It seems, however, that the great bulk of volunteers responded to mixed motives, none of which was deeply felt.

SMALL CONCERN IN IDEOLOGICAL ISSUES

The same was true of the more permanent or basic influences. One searches most letters and diaries in vain for soldiers' motives on why they were in the war or for what they were fighting. While the men in blue were not so irreverent toward high sounding appeals and patriotic sentiments as were their khaki clad descendants in World War II, yet American soldiers of the 1860's appear to have been about as little concerned with ideological issues as were those of the 1940's. For Billy Yank, as for his great-grandsons, the primary interests were physical comfort, food, drink, girls, furloughs, mail and gambling, in about that order, and ultimate objectives, sooner or later simmered down to finishing an unpleasant though necessary job as soon as possible and getting home.

Some fought to free the slaves, but polling the rank and file through their letters and diaries indicates that those whose primary object was the liberation of the negroes comprised only a small part of the fighting forces. It seems doubtful that one soldier in ten at any time during the conflict had any real interest in emancipation.

The hordes of young men whom the historian James Ford Rhodes represents as aroused to Republicanism and emancipation by *Uncle Tom's Cabin* seem either to have stayed home or to have lost the sharpness of their enthusiasm before joining the army. Yankees, who in their war letters and diaries, revealed even a knowledge of Mrs. Stowe's hero were rare.

CONDITION OF RECRUITS AT INDUCTION

Recruits were supposed to be checked for physical fitness, but apparently among early volunteers this provision was sometimes overlooked. And in many cases where it was observed the examination was a farce. Private Charles Barker of Massachusetts wrote in November, 1861, that the examining surgeon felt his collarbones and said, "You have pretty good health, don't you?" When Barker replied affirmatively the doctor remarked, "You look as though you did." After inquiring if the recruit had fits or piles the examiner marked him able for service.

Leander Stillwell, of Illinois, gave the following account of his examination:

> The surgeon, at that time, was a fat, jolly old doctor by the name of Leonidas Clemons. I was about scared to death when the Captain presented me to him, and requested him to examine me. I reckon the good old doctor saw I was frightened, and he began laughing heartily and saying some kind things about my general appearance.
>
> He requested me to stand up straight, then gave me two or three little sort of "love taps" on the chest, turned me round, ran his hands over my shoulders, back, and limbs, laughing and talking all the time, then whirled me to the front and rendered judgment on me as follows: "Ah, Capt. Reddish! I only wish you had a hundred such fine boys as this one! He's all right, and good for the service."

Little wonder that Frederick Law Olmsted after a 15 month investigation of recruiting conditions in the army reported to Lincoln in July, 1862: "The careless and superficial medical inspection of recruits made at least 25 per cent of the volunteer army raised last year not only utterly useless, but a positive incumbrance and embarrassment." Subsequently detailed examining procedures were prescribed by the medical

department, but these were in large measure nullified by failure to provide anything like an adequate staff of examiners.

MANY DEFECTIVES

The evidence came direct from the field. Fifteen to 20 per cent of the "three-months' men" were reported incapacitated by disabilities suffered before entering the service, which should have been detected by the examining surgeon. Chronic cases were clogging hospitals needed for battle casualties. They included syphilitics and men between 60 and 70 years of age, many of whom had hernias and some who were epileptics. They were particularly numerous in the 61st New York Volunteers; and the 5th New York Cavalry was said to have 80 epileptics and individuals with hernia.

Many of the volunteers, including one entire regiment gathered at Washington, had never been examined. At Camp Dennison, Ohio, most of the sick were men who should never have been enrolled. Three-fourths of the men discharged for disability, who stopped at the Sanitary Commission "Home" in Washington, belonged to that category. The medical director of the Army of the Potomac reported officially that of 3,929 men discharged for disability in October, November, and December, 1861, 2,881 had had the diseases or defects for which they were discharged, at the time of enlistment.

EXAMINATION REGULATIONS

The Army's regulations were not at fault. Imperfect as the prescribed routine for physical examinations seems to modern eyes, it would have uncovered most of the defectives had it been followed. "In passing a recruit," read a regulation, "the medical officer is to examine him stripped; to see that he has free use of all his limbs; that his chest is ample, that his hearing, vision, and speech are perfect; that he has no tumors, or ulcerated or cicatrized legs, no rupture or chronic cutaneous affection; that he has not received any contusion, or wound of the head, that may impair his faculties; that he is not subject to convulsions; and has no infectious disorder that may unfit him for military service." It was also provided that a recruit, enlisted and examined elsewhere, be reexamined on joining his regiment.

PERFUNCTORY PHYSICAL TESTS

The need for men, the ignorance of examining surgeons, the pleas of eager recruits and the pressure of "unscrupulous recruiting agents" led to scandalous abuses. Some surgeons merely looked at a recruit's legs and groin, then passed him; others did not have the recruit undress; one got through his task at the rate of 90 recruits an hour. At Chicago an examining surgeon was called out in the rain while a whole regiment paraded past him. He managed to tag "seven or eight obviously bad cases." So far as he knew, that regiment never had any further physical examination.

The examination of the 33rd Ohio ". . . consisted of but little more than opening and shutting the hands, bending the elbows and knees, and rotating the shoulder-joint, with a casual glance at the teeth and eyes, and a question as to age and previous general health." How perfunctory these examinations were is indicated by the estimated number of 400 women enrolled as soldiers.

With disabled men pouring out of his army as through a sieve, General McClellan took remedial steps. The first was the War Department's General Order 51, August 3, 1861, requiring regimental surgeons to examine their men. Neglect of this order led to the supplemental General Order 104, December 3, 1861, which called attention to the alarming losses through discharges for disability and provided punishment for delinquent surgeons.

Medical Director Tripler wrote dejectedly that the Army was apparently considered, "a grand eleemosynary institution" for defectives whose townships would thus be relieved of the burden of supporting them.

It is a sad fact of Civil War history that more men died of looseness of bowels than fell on the field of combat (57,265 diarrhea and dysentery; 44,238 killed in battle). Ignorance of the cause of disease was, of course, the fundamental factor in epidemics and death. A veteran of the Union Medical Corps, contrasting in 1918 practices of the Civil War and World War I stated: "In the Civil War we knew absolutely nothing of 'germs.' Bacteriology, the youngest and greatest science to aid in this conquest of death, did not exist; sanitation was crude and unsatisfactory; research had not yet discovered any of the antitoxins nor the role of the insect world in spreading disease."

TYPHOID AND DIARRHEA

The Civil War saw an enormous incidence of typhoid and diarrhea. Typhoid was the leading "killer" and diarrhea was a universal ailment. The soldiers nicknamed the diarrhea "the Tennessee quickstep," or the "Virginia quickstep" and so on down the list of states. There was no agreement as to what "dysentery" was, or what "diarrhea" was, or what caused either of them. Under the circumstances preventive measures would of necessity be fumbling.

Bowel diseases became increasingly deadly with the continuance of the war, owing to the cumulative tendency toward chronic conditions. An eminent medical scholar of the period, after visiting the Western military camps, said, "Bowel complaints might still further be reduced by the general adoption of the habit of wearing flannel

body bandages or stomach belts, of which there is a large number on hand."

TREATMENT

Diarrhea victims frequently had their bowels further irritated by heavy drafts of whiskey and repeated doses of salts or calomel, though many doctors discountenanced such procedures and followed milder practices. Opium was widely used in combating dysentery and some chronic cases were treated with strychnine. Other medicaments for bowel disorders were turpentine, castor oil, camphor, ipecacuanha, laudanum, blue pills (blue mass) of mercury and chalk.

Whiskey and quinine was the standard treatment for malaria, but other remedies including iodide of potassium, sulfuric acid, syrup of wild cherry, blue pills, morphine, ammonia, iron, cod liver oil, soda, sweet spirits of niter, cream of tartar and cinnamon. These might be used singly or in combination.

For typhoid, one surgeon gave his remedy as "blue pill and quinine," while another reported: "Treatment is alterative, tonic and stimulating by blue mass, carbonate of ammonia, turpentine, quinine and brandy." The methods of these two surgeons seem fairly representative. In coping with typhoid, as in treating diseases in general army doctors relied heavily on stimulants and purges. Resort to calomel became so excessive in the opinion of Surgeon General Hammond that he issued a circular in May, 1863, striking that medicine from the supply table of the army.

PRESCRIPTIONS—SIX, NINE, ELEVEN

Reactions of the men to army medical treatment, as might be expected, was predominantly unfavorable. One Yank who rose to the rank of major recorded his impressions after the war:

> The regular prescriptions were numbered six, nine, and eleven, which were blue pill, quinine, and vinum. We soon learned that "vinum" meant either wine or brandy. I have seen men count from right to left, "six, nine, eleven—six, nine, eleven—six, nine, eleven," and step into the line just where "eleven" would strike.
>
> It was a sure thing, since the surgeon gave in regular order, as the men filed past him, something as follows: "Well, what's the matter with you?" "I don't know, Doctor, I've got an awful pain in my bowels; guess I've got the chronic diarrhea." "Let's see your tongue! Give him number six!
>
> "Next, what's the matter with you?" "I was took with an awful griping pain in my bowels—guess I've got the chronic diarrhea." "Give him number nine! Next, what ails you?" "I've g-got an almighty b-b-bellyache, g-g-guess I've got the chronic d-d-diarrhea." "Run out your tongue! Give him number eleven!"

Another soldier wrote while serving in Virginia: "A man might as well die as 2 go through the rounds for (he is) . . . stufed with all kinds of poison & then Sent 2 the Invalid Corps . . . & if he is not able 2 do duty there, he is stufed with Poison agen 2 months longer . . . I had rather be here 10 years than 2 run the risk for I know what the medicine is they give, dont make (any) difference what ails you the same dose cures all, blue Pills & other stufe as bad."

"He prescribes 'salts' to everybody," complained a Pennsylvanian of his doctor, while a Connecticut Yank who had been on the sick list for three days wrote his sisters: "The first day Dr. gave me a powder that came very near turning my stomach inside out and today he gave me 20 drops of Aromatic Sulforic Acid 3 times a day; that goes better . . . I will inclose one of my powders. It will cure any ails that flesh is heir to, from a sore toe to the brain fever." A third soldier noted in his diary: "Sick, did nothing—went to Dr., he gave me a powder, wonder it want a pill."

Sometimes Yanks went to their captains for treatment rather than risk the doctor's cures. Members of Edward S. Redington's Company D, Twenty-eighth Wisconsin, received the benefit of an original remedy, hit upon by their captain in circumstances and with results stated thus by him:

"Have a slight attack of Helena Quickstep, but feel much better tonight and think I shall be all right in the morning. I have been taking quinine, pain-killer, and whiskey and my head feels rather large and rings like a kettle.

"The way they all got mixed was in this way: a bottle of quinine and pain-killer got broke in my medicine chest; the quinine soaking up the pain-killer, so I put them in another bottle and filled up with whiskey. A more villianous compound to swallow never passed a man's lips. I have given several of the boys out of the same bottle and it has always cured them without fail. I think I shall apply for a patent on it as a cure for all the ills the flesh is heir to from colic to cholera."

HOME REMEDIES

As previously noted, Yanks often chose to be their own doctors, and most who treated themselves claimed good results. One attributed robust health to keeping himself "dosed full of red pepper." Another cured his diarrhea with a patented product known as "Radways Ready Relief." The practice of one recuperating from "Yaller Janders," as he put it, is indicated by a plea to the homefolk to "Please send me some Flower and some salurates and Rusey save."

While the confidence of soldiers in their own curative efforts was undoubtedly exaggerated, still it cannot be denied that owing to the backwardness of medical science, shortage of supplies and professional incompetence Yanks sometimes

were as well off with home remedies as with the surgeon's services.

CONTAMINATED WATER

Contaminated water sent thousands of men to the hospital. Troops in the vicinity of Cairo, a concentration point for Western forces, regularly drank the impure water of the Ohio and Mississippi rivers, and a like practice was followed throughout the army with rivers, creeks, ponds, springs and shallow wells constituting the principal sources. Purification units were unknown. Medical authorities in some instances recommended that drinking water be boiled or filtered but the advice seems rarely to have been heeded.

The direful ignorance of water contamination even in supposedly informed circles was revealed by the following inspection report by the president of the United States Sanitary Commission:

> "The Mississippi water has a general reputation for wholesomeness. The Missouri mud, with which it is charged, in settling carries down whatever vegetable or animal substance may exist in the water and leaves it, though still colored, comparatively pure. The Ohio water, being more conveniently reached, is, however, chiefly used by the troops. They had all suffered diarrhea from the use of this water, or from change. It took about a fortnight to accustom them to it. The surgeons were doubting the expediency of going into the use of the Mississippi water from fear that another change might produce another excess of the same complaint."

It is doubtful if the doctors received any help from their distinguished inspector in solving their problem.

LACK OF SANITARY MEASURES

Pitching of camps in swamps, poor provision for drainage, and crowding together of tents occurred with shocking frequency. But far more injurious to health was the filth in which soldiers lived, especially in the early days of the conflict. Latrines, or "sinks" as they were called in Civil War times, were standard camp fixtures, but often these were shallow trenches left uncovered for long periods of time and located so near the quarters as to subject the occupants to nauseous odors.

Many Yanks from rural areas, accustomed at home to following the rule of convenience in answering nature's calls and shrinking from immodest exposure, declined using the sinks. Unfortunately the normal trend of camp life was in a back-to-nature direction, and some who at home had been fastidious in the observance of toilet practices, in the army became as indifferent as the most confirmed frontiersman.

Garbage disposal left much to be desired. A survey of 200 regimental camps in the latter part of 1861 revealed that 26 per cent of them were "negligent and slovenly" in this respect, and 24 per cent "decidedly bad, filthy and dangerous." Among evils reported were: "Camp streets and spaces between the tents littered with refuse, food and other rubbish, sometimes in an offensive state of decomposition; slops deposited in pits within the camp limits or thrown out broadcast; heaps of manure and offal close to the camp."

PERSONAL CLEANLINESS NEGLECTED

Neglect of personal cleanliness further darkened the picture. Army regulations prescribed daily washing of hands, and faces, biweekly ablutions of the feet and complete baths once or twice a week. But few were the companies early in the war that complied fully with these provisions and neglect was common in some units throughout the conflict. In 1861 men often went for weeks without bathing and without washing their clothing. For the latter, lack of a change of suits was sometimes given as an excuse.

Inadequacy of clothing and shelter was also a factor in poor health. This was especially true of the first winter of the war, when production and supply lagged considerably behind the enormous needs resulting from rapid mobilization and when ruthless contractors so frequently defrauded the government with inferior materials. Inspectors during this period often noted a shortage of overcoats as well as insufficient shelter against cold and rain.

DEFICIENCY OF NUTRITIOUS FOOD

Exposure to the elements, while injurious enough, produced far less illness than did food. The ration specified in army regulations authorized both fresh and "desiccated" vegetables, and it was contemplated that regular allowances would be supplemented by purchases from company funds obtained by credits for unused portions of the issue. But surpluses were commonly wasted instead of being applied to company funds, processed foods were spurned as unpalatable and fresh vegetables were hard to get. **The net result was to confine camp fare largely to salt pork, bread and coffee.**

Yanks frequently supplemented commissary issues by purchases from sutlers and peddlers but since the standard items in stock were pies and cakes, or "pi-zan cakes" as the colored vender's cry was sometimes translated, the results were more harmful than helpful. **The widespread deficiency of vegetables and fruits not only helped swell the sick list but slowed down recovery from illness and wounds and increased mortality.**

Despite persistent efforts by higher authorities to have food prepared in company quantity by experienced men detailed for the purpose, cooking was usually done by small groups or messes with each man taking his turn at the skillet.

The results were deplorable, owing to ignorance, lack of sanitation and a propensity for frying everything in a sea of grease. Even the flour was commonly mixed with water and fried as flapjacks. Culinary procedures improved with experience, but the general level of efficiency in food preparation remained lamentably low throughout the war.

POOR DISCIPLINE

As already implied, a basic factor underlying most unhealthful practices was incompetent leadership, especially on the regimental and company level. Discipline was especially poor during the early part of the war and to this circumstance, probably more than to any other, must be attributed the high tide of sickness which engulfed Federdal camps in 1861 and 1862.

Volunteer officers, ignorant of their responsibilities and fearful of offending the men who elected them, were slow to lay down rules of sanitation and diet and even more reluctant to enforce them.

(To be concluded in June issue)

Doctors Under Three Flags, by Fannie Anderson, (\$3.50. *Wayne University Press, Detroit, Michigan),* was written by the well-known medical bibliographer of medical literature who at present is a member of the staff of the Medical Library of Wayne University. Her interests in medical history and in her home town prove a happy combination which makes this interesting account of Detroit Medicine.

The book was published through the professional and financial assistance of Dr. Alfred Whittaker, descendant of one of the past leaders of medicine in Cincinnati, and himself a most active alumnus of the College of Medicine of the Ohio State University.

Anyone who is interested in local medical history or the history of Michigan will want this book in his library. Mrs. Anderson not only has traced the story of medicine as practiced in Detroit from 1701 to 1837 but has integrated this story into the broader pattern of the city's history. The part the doctor and his profession played in the growth of the stockaded village in the wilderness during 136 years until it became a thriving city is told in a most interesting manner.

The First Hundred Years of The Mount Sinai Hospital of New York, 1852-1952, by Joseph Hirsh and Beka Doherty, (\$5.00. *Random House, New York City),* is in fact the story of medical progress in this country against the background of one of its most progressive and productive institutions.

Rheumatoid Arthritis An Age-Old Disease

Arthritis has been afflicting the human race since the beginning of civilization. The Romans recognized certain forms of hydrotherapy in the treatment of arthritis. This was evidenced by beautiful baths, built of stone and marble, near the location of hot springs. The baths excavated at Bath, England, and Aix les Bains, France, contained warm water and sweating chambers made of stone, and they are partially intact to this day.

During the 17th Century the treatment of rheumatism was largely in the hands of quacks, such as Mrs. Mapp the "bone setter." She would ride three times a week from Epsom to London with six outriders in scarlet preceding her. Another, Sir James Jay, was knighted by George III of England.

In 1676 Sydenham, partly as the result of personal experiences, separated gout from other forms of rheumatism. There was no difference between the treatment of gout and rheumatism during the 18th Century. The object in both cases was to depress the fever, if any, and to drain off the "acrid substances" which were assumed to be causative.

A useful summary of the treatment of rheumatism in the first quarter of the 18th Century is given by Boerhaave. He states that rheumatism "is always cured by bleeding, cooling, repeated purges, ally'd at night with a narcotic; gently bathing in warm water, antiphlogistic fermentations, and blisters to the part; a thin spare diet, rest, the warmth of a bed, and toward the latter end by dry, hot frictions together with the use of antiscorbutics." This sentence is probably the first reference to massage in English medical literature.

Latham, in his book (1796), was the first to state that "therapy must be adapted to the stage of the disease, and a knowledge of the normal." As the result of this new trend in therapeutics at the end of the 18th Century, most of the leading physicians came to adopt some form of "expectant treatment."—C. Stewart Gillmor, M.D., Kansas City; *J. Missouri S. M. A.*, 49:976, Dec., 1952.

The History of American Epidemiology, by Drs. Winslow, Wilson, Smillie, Doull, Gordon, and edited by Franklin H. Top, M. D., (\$4.75. *The C. V. Mosby Co., St. Louis 3, Mo.),* covers the story from 1607 to the present time. The American contributions to the field are relatively recent in the long history of medicine. The infectious diseases that scourged the American settlers were brought from the four corners of the earth and knowledge concerning them and their control was largely the result of Old World thought and indoctrination in colonial times. In recent times America's contributions have been more substantial.

Proceedings of The Council . . .

Heavy Docket Considered at Meeting on March 21-22 . . . In Addition to Routine Business, Governing Board Acts on Bills Before Legislature

MEETINGS of The Council of the Ohio State Medical Association were held in the Columbus office on Saturday evening, March 21, and Sunday, March 22, 1953. All members of The Council were in attendance except Dr. Fred W. Dixon, Cleveland; Dr. Charles L. Hudson, Cleveland; Dr. R. J. Foster, New Philadelphia. The Sunday meeting also was attended by four members of the Legislative Committee: Dr. G. A. Woodhouse, Pleasant Hill, chairman; Dr. Floyd M. Elliott, Ada; Dr. James B. Johnson, Jr., Newark; and Dr. D. J. Slosser, Defiance. Others in attendance were Dr. C. C. Sherburne, Columbus, an A. M. A. delegate; Dr. H. M. Platter, Columbus, secretary of the State Medical Board; Dr. Robert Conard, Wilmington, chairman of the Military Advisory Committee; and Messrs. Nelson, Saville, Page and Moore.

The minutes of the meeting of The Council held on December 14, 1952, were approved.

The following membership statistics were presented by the Executive Secretary: Total paid-up membership in the Ohio State Medical Association as of March 20, 6,572. Total number of O. S. M. A. members paying A. M. A. membership dues for 1953 as of March 20, 5,322. These figures compare with 7,806 as of December 31, 1952, for O. S. M. A. dues and 6,440 O. S. M. A. members paying A. M. A. dues.

PRO-RATA DUES SET

On **motion** duly made, seconded and **carried**, The Council authorized the pro-rating of Ohio State Medical Association membership dues for the third and fourth quarters of 1953 for new members as follows: Dues for **new members** affiliating during the third quarter, $15.00; dues for **new members** affiliating during the fourth quarter, $10.00.

An amendment adopted in October, 1952, by the Scioto County Medical Society to the by-laws of that society, increasing the local dues of the society, was approved by The Council. An amendment adopted by the Scioto County Medical Society in February, 1953, to provide for a one-year probationary period for applicants for membership in that society, was discussed. Action was deferred pending clarification of the wording of the amendment. The Executive Secretary was instructed to convey to the Scioto County Medical Society suggestions from The Council concerning the wording of the proposed amendment.

An official notice from Ohio Medical Indemnity, Inc., announcing the annual meeting of stockholders on April 1, 1953, was considered.

On **motion** duly made, seconded and **carried**, the following were authorized to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of O. M. I. on all business matters coming before that meeting: Dr. H. M. Clodfelter, Columbus, or Dr. C. C. Sherburne, Columbus, or Mr. Charles S. Nelson, Columbus.

ANNUAL MEETING

The Executive Secretary reported on arrangements and details to date for the 1953 Annual Meeting, April 21-23, Cincinnati.

At the request of the President, Dr. Robert Conard, Chairman of the Military Advisory Committee, presented a detailed report on the activities of his committee, including the work he had carried on in organizing the setup in the Columbus office.

A. M. A. SESSION

Dr. Woodhouse, Dr. Sherburne and Dr. Davis presented a verbal report on the transactions at the special meeting of the House of Delegates of the A. M. A. in Washington on Saturday, March 14, at which time the A. M. A. House of Delegates went on record as approving the reorganization of the Federal Security Administration by creating a Department of Health, Education and Welfare with cabinet status.

A communication received from the Ohio State Pharmaceutical Association, relating to the problem of telephoned narcotic prescriptions, was discussed. The communication referred to a proposal from the medical society and the pharmaceutical society of Montgomery County which would entail Federal and state legislation. The Council referred this matter to the Committee on Public Relations and Economics for consideration and study with a suggestion that a conference be held with representatives of the Ohio State Pharmaceutical Association on this matter.

HOSPITAL PROBLEM

The Council then considered a letter from the director of an Ohio hospital, asking for advice and suggestions on a question of dealing with osteopaths. The inquiry involved a question as to whether or not it would be proper for physicians in the hospital's cancer clinic to furnish a report on a patient following examination, to an osteopath who had referred the patient to the

clinic and who is regarded by the patient as the patient's family physician.

On **motion** duly made, seconded and **carried**, The Council adopted a statement to the effect that there would be no objection to the physicians of a clinic of this kind conveying information regarding diagnostic findings to any duly licensed physician, which would include osteopaths licensed in Ohio to practice osteopathy and surgery or osteopathic medicine and surgery, inasmuch as this procedure is deemed to be in the best interests of the patient.

AUTOPSY CODE APPROVED

A suggested code for autopsy procedures in Ohio was reviewed by The Council. This document had been prepared following joint conferences on the part of representatives of the Ohio State Medical Association, Ohio Society of Clinical Pathologists, Ohio Funeral Directors Association and Ohio Coroners Association. Work on the document has been going on for approximately one year.

Inasmuch as the suggested code appeared to represent the thinking of representatives of all the groups and is the result of many conferences and careful study, The Council, on **motion** duly made, seconded and **carried**, approved the suggested code for autopsy procedures; instructed the Executive Secretary to advise all groups interested of this action; and to request the Committee on Public Relations and Economics to supervise any follow-up activities which would be necessary in order to place the code into effect.

TELEPHONE LISTINGS

A communication from a county medical society, accompanied by a letter from a member of that society objecting to the present form of listing osteopaths in the telephone directory, was discussed. After lengthy consideration of this question, The Council on **motion** duly made, seconded and **carried**, instructed the Executive Secretary to advise the Summit County Medical Society that it could see no objection to a telephone directory carrying a heading "Physicians and Surgeons (M. D.)," under which would be listed the names of licensed doctors of medicine, and a heading "Physicians and Surgeons—Osteopathic (D. O.)," under which would be carried the names of duly licensed osteopathic physicians. It was pointed out in the discussion that licensed osteopaths are regarded legally in Ohio as physicians and surgeons and that the only designation necessary would be to show that they are osteopathic practitioners and that their names be listed separately from the list of doctors of medicine.

BLOOD TESTING PROGRAM

A communication from Dr. John D. Porterfield, State Director of Health, regarding a proposed mass blood testing program as a case-finding procedure for chronic syphilis to be carried on in Lawrence, Gallia and Scioto counties, was discussed. In his letter Dr. Porterfield requested approval of the project by the Ohio State Medical Association. The Council adopted a motion approving the project in principle, but recommended that it not be instituted in any county without the approval of the county medical society.

MISCELLANEOUS ACTIONS

A letter from the president of a county medical society, requesting the State Association to waive annual membership dues in cases of extreme hardship, although such members may not be retired from practice, was read and discussed. The Council instructed the Executive Secretary to point out to the county society officer that dues could not be waived for such cases under the present provisions of the By-Laws of the Ohio State Medical Association and that amendment of the By-Laws would be necessary in order to cover cases of this kind.

By official action, The Council authorized the Managing Editor of *The Journal* to publish factual information in *The Journal*, based on the record of official disciplinary action taken by any county medical society against a member found guilty of violating the constitution and by-laws of such society.

A request from the American Legion of Ohio for a conference with representatives of the Ohio State Medical Association on questions of mutual interest was discussed. By official vote, the President was authorized to name a special committee of five to meet with representatives of the American Legion at a mutually agreeable time.

A communication from Dr. Herman J. Bearzy, Dayton, requesting the establishment of a section on physical medicine and rehabilitation, was considered. On **motion** duly made, seconded and **carried**, the Committee on Scientific Work was requested to give serious consideration to this request when the program for the 1954 Annual Meeting is being formulated, and that the Executive Secretary write to Dr. Bearzy explaining in detail the purposes, functions and responsibilities of such a section.

POLICIES ON PENDING BILLS

At its session on Sunday, The Council reviewed the provisions of approximately 60 bills now pending before the Ohio General Assembly, all of which have some medical or health angle. Official action taken by The Council on some of the proposals follows, it being understood that endorsement implies that the measure is in acceptable form as to administrative details and otherwise:

Chiropractic and naturopathic bills: Active opposition in line with previous policy on such proposals.

To re-organize state licensing boards: Active

opposition to reorganization; will cooperate in considering reasonable amendments to administrative practices act to correct proven abuses.

Uniform State Food, Drug and Cosmetic Act: Approval in principle; careful analysis of detailed provisions and any amendments.

To authorize the Attorney General to make a study of the narcotics problem in Ohio and various bills increasing penalties for narcotic violations: —Approval of proposal for study by Attorney General; approval in principle of bills tightening up controls and penalties.

To create a new Department of Mental Hygiene and Correction: Present policy of Association is for improvement in the preventive and rehabilitation aspects of Ohio Mental Hygiene program. Will support proposal for new department if that is necessary to improve preventive and rehabilitation activities and to provide more competent medical control of this program. Possibilities for improvement under present setup should be studied and explored and appropriate action recommended which may make creation of separate department unnecessary.

Practical Nurses Bill: Previous policy of 1949 approving in principle this type of legislation, reaffirmed. Approval of setup of licensing by State Nurses Board. Disapproval voted on a separate board for licensing of practical nurses.

Subsidy for nurses training school: Approval withheld for the reason that the entire subject needs more study and investigation.

To increase the State Nurses Board by adding two hospital administrators: disapproved as unnecessary and undesirable.

To create a Division of Alcoholism in the State Department of Health: Approved in principle; details should be studied carefully; amendments suggested if necessary.

To transfer restaurant inspection from the State Fire Marshal's office to the State Department of Health: approved.

To transfer restaurant inspection from the State Fire Marshal's office to the State Department of Agriculture: disapproved.

To provide for nomination and election of county coroner on a non-partisan ballot: approved.

Proposal for the licensing of hospitals and rest homes: Approved in principle; details to be analyzed carefully; amendments to be offered, if necessary.

To raise the salary of the State Director of Health to $14,000.00 annually: approved.

Re-enactment of Wheeler Bill to provide that public health levies shall run for a period up to five years: approved.

Permits townships to enter into agreement with cities for building and management of a hospital: approved.

Change of procedure in the handling of county hospital funds: approved.

Permits city councils to lease city owned hospitals to non-profit, non-sectarian groups for use as a general hospital: approved.

To permit a city health district to contract with a district advisory council for public health services: approved.

Permitting state tuberculosis hospitals to retain non-tuberculosis patients for a reasonable time after diagnosis of non-tuberculosis is made: approved.

Legislative request of Ohio State University College of Medicine for additional facilities: approved.

Bills to increase state allowance for medical and hospital care of recipients of aid for the aged: need for some increase supported.

To create a State Division of Vocational Rehabilitation—no action; need for more information and study.

No specific action was taken on many other bills now pending. The legislative Committee and the Columbus office staff were instructed to watch all of them carefully; to secure advice from The Council, if necessary, prior to action which might be required.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

Dr. Allan C. Barnes Appointed To Western Reserve Post

Dr. Allan C. Barnes, Columbus, professor and chairman of the Department of Obstetrics and Gynecology at Ohio State University College of Medicine, has been appointed Arthur H. Bill Professor of Obstetrics and Gynecology at Western Reserve University School of Medicine and head of Department of Obstetrics and Gynecology at University Hospitals in Cleveland. The appointment is effective July 1.

Dr. Barnes received the 1952 foundation award of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons for a report on "Body Production of ACTH in Response to Gynecologic Surgery and Irradiation."

International Academy of Proctology

All physicians are invited to attend the Fifth Annual Convention of the International Academy of Proctology to be held at the Plaza Hotel, New York City, May 29, 30 and 31 directly preceding the American Medical Association Meeting.

The program is available upon request to the Executive Offices of the International Academy of Proctology, 43-55 Kissena Blvd., Flushing, New York.

Code for Autopsy Procedures . . .

Suggestions To Guide Physicians, Funeral Directors and Hospitals Are Compiled and Agreed to by Groups Affected . . . Complete Text Published

FOR more than a year, representatives of the Ohio State Medical Association, Ohio Funeral Directors' Association, Ohio Hospital Association, and Ohio Society of Pathologists have been working on the formation of a suggested "Code for Autopsy Procedures" to be used as a guide by members of all groups concerned in their relationships with each other.

The code is meant primarily as a local guide of conduct and procedure and as a basis for working out in an amicable manner any problems or controversies which may arise.

At its meeting on March 21, The Council of the Ohio State Medical Association approved the code. It has been approved also by the official boards of the other organizations mentioned above.

Complete text of the code is as follows:

CODE FOR AUTOPSY PROCEDURES

CHAPTER I

PREAMBLE

Section 1. In order to maintain a closer relationship between all parties involved and with the welfare of and service to the public in mind, the following points should be considered and every effort should be made by all concerned to help each other in their respective field.

Section 2. It is mutually agreed that this suggested code of autopsy procedures is not to interfere with any agreement or code already working satisfactorily in any local community but rather as a guide in settling differences should they arise.

Section 3. All agree that postmortem examination by a pathologist is desirable; first, to provide reliable recorded information concerning the cause of death and the nature of the various disease processes; second, to confirm or amend the opinions formed by physicians during the life of the patient, so that they may serve patients with greater confidence and skill; third, to reveal continually to physicians the physical changes in the interior of the body; and fourth, to provide for the advance of human knowledge concerning the nature of disease in general.

Section 4. It is desirable that all autopsies should be performed by a pathologist or by a competent assistant under the supervision of a pathologist.

Section 5. The fact that the deceased human body is subject to immediate decomposition and postmortem changes in the skin, face, hands and other tissues, (i. e., postmortem staining and lividities, collapse of circulatory system), changes which cannot be effaced by the embalmer, it follows that immediate attention should be given to the body so as to prevent or retard as many physical and chemical changes as possible.

Refrigeration delays these changes somewhat but impedes the work of the embalmer in many respects. Therefore, refrigeration should only be used when unreasonable delay cannot be avoided and arterial embalming is not feasible or when the physical condition in the morgue makes refrigeration imperative.

In order to avoid delay and embarrassment to the family and all concerned as a direct result of the above-mentioned postmortem changes and the problems thereby created, every effort should be made to avoid any unnecessary delay in embalming the body as soon as possible after death has occurred. This will require perfect coordination and cooperation between all parties concerned in order to expedite the obtaining of autopsy permits, performance of the autopsy, release of the body, and performance of the embalming.

From the viewpoint of the embalmer, it is commonly desirable to inject the body arterially before the autopsy is performed. From the viewpoint of the pathologist, it is frequently desirable that the arterial injection not be done until after the completion of the autopsy. Agreement on this point should be consummated by the local parties concerned.

CHAPTER II

PRE-AUTOPSY PREPARATION AND CARE OF THE BODY

Section 1. In hospital autopsies, the hospital should provide and be responsible for the following, in order to expedite the obtaining of autopsy permits, performance of the autopsy and the release of the body:

(A) The hospital personnel should be responsible for informing all members of its medical and nursing staffs of the importance of securing autopsy permits and arranging for the postmortem examination at the earliest possible time. It is improper for any member of the hospital staff to threaten to call the coroner if permission for autopsy is refused. If the permission to

perform the autopsy is not secured within a reasonable time, the funeral director selected by the family should be notified and satisfactory arrangements agreed upon. In securing autopsy permits, there should be no misrepresentation to the family regarding the size of incisions, the time of release of the body, etc.; or the use of threats or duress. These may jeopardize the position of the funeral director and the embalmer or reflect on the skill of the pathologist.

(B) Bodies should be sent immediately to the hospital morgue or autopsy room after preliminary laying out of the body in the patient's room. The head and shoulders should be elevated to prevent postmortem blood staining in the normally exposed portions of the body. The arms should be crossed over the trunk and held by wide cotton padded gauze strips above the elbows, not at the wrists. The eyes should be closed. Nothing should be placed under the eyelids, as this stretches the soft tissues of this area. The mouth should not be closed. Strips of gauze used for this purpose leave objectionable marks on the face. Surgical dressings should be left in situ. Diaper type pads should then be used and the body covered, but not wrapped.

(C) The hospital should notify the funeral director as soon as instructed by the family, stating whether or not an autopsy is to be performed and should notify the pathologist as soon as the autopsy permit is signed. Failure to do this causes embarrassment for the funeral director and the hospital authorities. The family expects the funeral director to contact them at once regarding arrangements. Delay in this matter greatly increases the family's burden.

In cases where the funeral director is contacted directly by the family of the deceased, he should telephone the hospital to ascertain whether an autopsy is to be performed, rather than go to the hospital unannounced to remove the body.

(D) The hospital authorities should maintain proper organization facilities and equipment for securing autopsy permission and for performing autopsies, including:

a. Suitable instruments and other equipment required by the pathologist;

b. A uniform standard consent form for autopsy, if possible;

c. Proper instructions to all employees concerned with the arrangements for autopsies, such as: hospital management and staff (medical and nursing), office clerks, telephone operators, and orderlies, so that they may intelligently and efficiently attend to the necessary details;

d. Refrigeration facilities in the pathology department. Refrigeration temperature should be 38 to 40 degrees F.

Section 2. The time of performing autopsies should be as soon as possible after permission for such has been obtained, except in cases where an arrangement is made between the funeral director and the pathologist to embalm the body arterially before autopsy. Where such an arrangement is made, the funeral director should cooperate with the pathologist by returning the body to the hospital, if it has been removed, in order to avoid inconvenience to either the hospital or the pathologist in setting the time and place for the autopsy.

The pathology department of the hospital should notify the funeral director when the body is to be released. The body should be released within a maximum of six hours after consent for the autopsy is secured. In case shipment of the body is to be made, or for other urgent reasons, the funeral director must expedite the necessary preparations, the pathologist should be notified so that he may give the funeral director the utmost cooperation in releasing the body.

The pathologist should transmit his diagnosis to the attending physician as soon as possible to facilitate immediate completion of the death certificate.

Section 3. The funeral director or his attendant should not call at the hospital for the body until it has been definitely established that the body is ready for release to him. In case partial embalming or other technical assistance is desired after consultation with the pathologist, the funeral director or embalmer should provide the services required in accordance with the arrangements made. The funeral director or embalmer should cooperate with the hospital in helping to locate the relatives in order that delays in obtaining written permission for the autopsy may be reduced or avoided.

It is improper for an embalmer or a funeral director to in any way or by any means dissuade a family from granting permission for an autopsy or to influence them to change their minds after permission has been given.

It is understood that the funeral director will refer relatives or other people to the physician in attendance or to the pathological department of the hospital whenever any question regarding autopsy is raised.

If relief of abdominal or thoracic pressure becomes unavoidable during the course of preautopsy arterial embalming, the embalmer and pathologist should confer and decide whether to proceed with the autopsy at once or use a trocar.

CHAPTER III

CONDUCT AND TECHNIQUE OF THE AUTOPSY

Section 1. The type and location of incisions will vary according to the type and extent of the autopsy. In all cases the incisions should be

sharply and cleanly cut. Tearing or ragged edges should be avoided.

In general, straight-line or mid-line incision is acceptable for male cases and "Y" and crutch or sub-breast incisions are preferable for females, children and Navy personnel.

Should it be necessary to turn the body over in examining the spinal column, the forehead should be placed on a support sufficiently high to prevent any of the facial features from touching any surface. The entire face and particularly that portion of the forehead resting against the support should be covered with a heavy cotton pack.

In a partial post mortem, all incisions should be as small as possible. When it is necessary to remove tissues from the neck, cheeks, orbits or mouth, the head should be embalmed before this operation is performed as the slightest disturbance of tissues causes swelling during embalming.

Where a section of an artery is to be removed (i. e., of the extremities), both cut ends should be ligated prior to removing the sections, unless the body has been previously embalmed.

Section 2. In cranial post mortems, an incision should be made from the region behind one ear transversely over the vertex to the same region behind the other ear.

When working on the head special care should be used to preserve the facial features. The anterior saw cut should not extend more anteriorly than the hairline in all cases where examination may be completed with this type opening. If the cut is made on the frontal bone a ridged appearance is difficult to avoid when the calvarium is replaced. The posterior cut should be made as posterially as possible and should meet the anterior cut at a point on the mastoid process of the temporal bone forming an obtuse angle.

Where autopsy is performed prior to arterial embalming and the brain is to be removed, the ends of the internal carotid and the vertebral arteries should be left as long as possible and ligated prior to removal of the brain. The facial features should not be distorted for any reason during the autopsy. At the completion of the cranial autopsy the scalp may be sutured with loose stitches or the skull packed with plaster and the scalp sutured tightly, depending on local agreements.

Section 3. The type and extent of the autopsy will dictate the type of incision and conduct of the examination. However, certain techniques and procedure should be followed, namely:

(A) An incision in the posterior abdominal or thoracic wall or an oblique incision in the abdominal wall should be avoided, if possible.

(B) Surgical incisions near the midline should be utilized as far as possible.

(C) Only in exceptional circumstances should the scrotum be opened. The testes should be removed through the inguinal canals.

(D) During the thoracic autopsy the breast plate should be removed completely and in no way allowed to distort the facial features.

(E) Major arteries should be cut or ligated at point of origin from the aorta.

(F) The external iliacs should remain intact and major branches should be properly ligated as they are used for injection purposes in the interior portion of the body.

(G) In any case where material is to be removed from the neck regions for observations, the carotid and subclavian arteries should remain intact and major branches tied.

(H) Care should be taken not to sever the rectum too short. Ligate the stump. To prevent leakage, the pelvic floor should not be cut.

(I) If the stomach, small or large intestine, urinary bladder or the gall bladder are to be emptied, this should be done in a manner to prevent the contents from draining within the body cavities.

CHAPTER IV

CONTROL AND EDUCATION

Section 1. If any violation of this code occurs, an effort to adjust the differences should first be made by the funeral director, the pathologist and the hospital concerned or by a local coordinating committee appointed for the specific purpose of considering local violations.

If no agreement is consummated through such efforts, the violation may be referred to the State Autopsy Procedures Committee. Such committee should be selected annually and should be composed of the following: One member selected by the Ohio Society of Pathologists; one member selected by the Ohio Hospital Association; one member selected by the Ohio Funeral Directors Association; one member selected by the Ohio Embalmers Association; and one member selected by the Ohio State Medical Association.

All complaints submitted to this committee should be in writing. Decisions and recommendations made by the committee with respect to complaints considered by the committee should be transmitted to the organizations concerned for appropriate action.

Should a member of the committee be involved in a dispute and such dispute is referred to the committee for investigation, an alternate should be selected from the organization which he represents to temporarily take his place on the committee.

Section 2. Copies of this code shall be made

GOING TO THE A.M.A. MEETING? IF SO, BETTER REGISTER IN ADVANCE BY MAIL; ONLY MEMBERS ELIGIBLE TO REGISTER

OHIO physicians who plan to attend the 1953 annual session of the American Medical Association, New York City, June 1-5, should take advantage of the opportunity to register in advance by mail, thus avoiding congestion at the Registration Headquarters at the Grand Central Palace.

To be eligible to register, a physician must be a 1953 member of the A.M.A. Membership dues are payable through county medical society secretaries for forwarding to Columbus Office which transmits dues to Chicago.

Advance registration cards for the N. Y. session are being sent to 1953 A.M.A. members by mail from Chicago. Those who do not receive a pre-convention registration card should ask the Chicago Office of the A.M.A. for one.

If a physician decides to wait to register upon arrival in New York, he should have his 1953 A.M.A. membership pocket card with him for presentation at the Registration Headquarters.

If you are planning to attend, make sure you are a 1953 member. If you are not a dues-exempt member, better see your local secretary at once and pay him 1953 A.M.A. dues of $25.00.

available to all participating organizations for distribution to their members.

A copy should be posted in the morgue or autopsy room of every hospital and in the embalming room of every funeral home in Ohio.

It is recommended that this code be made a part of the curriculum of all embalming, medical and nursing schools in Ohio.

CHAPTER V

LEGAL LIMITATIONS

Nothing in this Suggested Code for Autopsy Procedures shall take precedence over any section of the Revised Code of Ohio dealing with the duties and responsibilities of the County Coroner or over any other section of the Revised Code of Ohio.

Otolaryngology Assembly

The Department of Otolaryngology, University of Illinois College of Medicine, has announced its Annual Assembly in Otolaryngology, divided into sections:

Basic Section, September 21 through 26, 1953, devoted to surgical anatomy and cadaver dissection of the head and neck, and histopathology of the ear, nose and throat, under the direction of Dr. M. F. Snitman.

Clinical Section, September 28 through October 3, 1953, consisting of lectures and panel discussions, with group participation of otolaryngological problems and current trends in medical and surgical management.

Registration will be limited. Application for attendance at one or both sections will be optional. For information write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Bequest Gives Western Reserve Two Millions for Research

More than $2,000,000 will accrue to the Western Reserve University School of Medicine from a bequest in the will of Mrs. Gertrude Chandler Tucker, late of Willoughby.

Under her will, which has been filed in Lake County Probate Court, the medical school is to receive all but a small fraction of her estate for research pertaining to children's diseases. Its net income is to be used for any one or a combination of the following purposes: To conduct researches and make studies of children's disorders; to employ personnel and provide needed facilities and equipment for the research, and to publish and circulate results of the studies and researches.

The University Board of Trustees, however, is given power to use the funds in other medical and surgical fields if it so choose.

Comprehensive Course in Rheumatic Fever Offered in New York Area

St. Francis Sanatorium for Cardiac Children (non-sectarian), Roslyn, Long Island, N. Y., has announced a comprehensive post-graduate course in rheumatic fever and rheumatic heart disease from June 1 through June 12.

As in previous years, the course is given for physicians, public health officers and members of the medical profession who are engaged in rheumatic fever projects. The fee is $100.

Dr. Ralph E. Dwork, chief of the Division of Chronic Disease of the Ohio Department of Health, reported that his Division has available training funds to train "key" people for programs of this kind. He has invited members of the profession who are interested to make application for coverage of the fee and travel expenses to take this course.

Doctors and the War . . .

Hershey Halts Call of Priority III Physicians in Upper Age Brackets; Essential Provisions of Proposed New Doctor Draft Law Are Reviewed

LOCAL Selective Service Boards have been ordered by General Hershey, Director of Selective Service "to cease immediately" the physical examination and induction processing of all Priority III physicians who were born prior to August 31, 1922.

Any outstanding orders to report for induction in the case of physicians born prior to August 31, 1922, are to be cancelled.

The processing of all Priority I and II physicians, all ages, and all Priority III physicians born after August 30, 1922, who are presently available for induction or who will become so available upon the completion of their current internship or residency should be expedited in order that they will be available to fill the May and June quotas, Hershey has told local boards.

This order was made necessary because it was found that many older men in Priority III had been examined and found acceptable while there were still men in the younger ages who had not yet been examined. The law requires that those in Priority III be called in order of age, the youngest first, and failure of local boards to call up these men in that order led to this inequity.

Dr. Robert Conard, chairman of the Association's Military Advisory Committee, reported that copies of Information Bulletin No. 12, Vol. IV, National Advisory Committee, have been sent to all County Military Advisory Chairmen, and members of the State Advisory Committee and members of Council, giving details of the difficulties which have been encountered in the call of men in Priority III in the past two months.

This information will be available to anyone who is interested through his County Advisory Chairman, Dr. Conard said.

PROPOSED NEW DOCTOR DRAFT LAW

Shortly before this issue of *The Journal* went to press, the Washington Office of the American Medical Association analyzed the essential provisions of the Defense Department's bill to amend and extend the Doctor Draft Law. The analysis was made before any hearings had been scheduled before Senate and House Armed Services Committees, looking toward enactment of the law before July 1, expiration date of the present law.

The report is purely factual on the provisions of the bill. No effort was made in this summary to criticize the bill nor to consider points that might have been mentioned but were not, such as the extent of dependent care and the ratio of physicians to troops, Dr. F. E. Wilson, of the Washington Office, points out. The memorandum read as follows:

Note: In all cases below reference is to "medical, dental and allied specialist categories" covered by the bill. Also, unless otherwise noted, reference is to reserves as well as to non-reserve special registrants inasmuch as the bill groups them together with these words: "The President is authorized to order to active duty . . . members of the reserve components who . . . but for such membership would be liable for registration."

PRIORITIES

The existing four priorities would be retained. Most men in Priorities I and II (government-educated or World War II draft-deferred for educational purposes) already have served or are now in uniform. Remaining are Priority III (non-veterans) and Priority IV (those with service, if even for a day). Priority III men now are being called, with the youngest first. When Priority IV is reached, presumably those with the least service will be taken first, as suggested in present law.

Required Length of Service (in the absence of a declaration by Congress of war or national emergency). The bill calls for a maximum 24 months' service with these exceptions: 1. **Reservists** and **non-reservists** who have served 12 months or more since June 25, 1950, could not again be called under the Doctor Draft Act. 2. **Reserves** who have served 12 months or more since Sept. 16, 1940, but not in the period since June 25, 1950, could be required to serve no more than 17 additional months.

PRIOR 'ACTIVE DUTY'

For purposes of prior service credit, active duty is defined as time spent (a) on active duty or active duty for training in Army, Navy, Air Force, Marine Corps, Coast Guard, or U. S. Public Health Service, (b) on non-military duty prescribed for a conscientious objector, and (c) in the military service of a co-belligerent of the U. S. in World War II. Not accepted as active duty would be time spent in ASTP, V12, or similar training programs, or in "intern training, residency training, or other postgraduate training or in senior student programs prior to receipt of a professional degree."

Liberalization of Commissioning Procedure. The bill attempts to assure that a man's **professional qualifications** shall determine his commis-

sion. The pertinent section states that any reservist on duty or ordered to duty "shall . . . be appointed . . . reappointed, or promoted to such grade or rank as may be commensurate with his professional education, experience, or ability." A Defense Department analysis of the bill adds: "This provision will insure that physicians, dentists, veterinarians, and allied specialist personnel will be given the rank to which they are entitled because of their professional qualifications without regard to whether they have previously served on active duty or have previously been commissioned as reserve officers." The bill specifically waives a section of the Armed Forces Reserve Act of 1952 which states: ". . . a person who has not held an appointment as a commissioned officer in any of the armed forces of the U. S. . . . may not be commissioned in a grade higher than major or lieutenant commander . . ."

Termination of Reserve Commissions. Unless an officer had obligations for reserve service not originating in the Doctor Draft Act, his reserve commission would terminate automatically upon completion of his active duty. This provision would be retroactive to Sept. 9, 1950.

NATIONAL ADVISORY COMMITTEE

The National Advisory Committee to Selective Service (Rusk) in conjunction with state and local affiliates would continue with present responsibilities, and in addition would be specifically authorized to "make determinations with respect to persons in residency training programs who shall be recommended for deferment . . . (and) with respect to members of the faculties of medical, dental, and veterinary schools and schools of public health, having due regard to the respective needs of the Armed Forces and the Civilian population."

Other Provisions. Maximum induction age remains at 51 . . . Aliens otherwise qualified for service would not remain ineligible for commissioning solely because of their alien status or because they have not declared their intention of becoming citizens . . . Technically this proposal would amend the Doctor Draft Act, which is a part of the basic Selective Service Act. The bill would move up the expiration date for the Doctor Draft Act from July 1, 1953, to July 1, 1955, when the Selective Service Act itself is scheduled to expire.

Course in Gastroenterology

The National Gastroenterological Association announces that its Fifth Annual Course in Postgraduate Gastroenterology will be given at the Hotel Biltmore in Los Angeles, Calif., on 15, 16, 17 October 1953.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, N. Y.

New Members of O.S.M.A.

Following are the names of new members of the Ohio State Medical Association since February 11, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ASHTABULA COUNTY
Coleman, Peter F., Ashtabula

CLARK COUNTY
Gianakopoulos, James G., Springfield
Parker, George F., Springfield

CLINTON COUNTY
Hamilton, Maxine, Wilmington

COLUMBIANA COUNTY
Milligan, James R., Salem
Ringsmith, Paul P., Hanoverton

CUYAHOGA COUNTY
Ballintine, Elmer J., Cleveland
Balsevisius, Petras, Cleveland
Christie, James H., Cleveland
Fanney, Grafton C., Jr., Cleveland
Gold, Harold, Cleveland
Hahn, Edward O., Cleveland
Hellerstein, Mary F., Cleveland
Hilfer, Richard J., Cleveland
Huntress, William W., Cleveland
Lewin, Anna J., Cleveland
Ling, Alexander, Cleveland
Moore, Douglas J., Cleveland
Mortimer, Edward A., Jr., Cleveland
Wells, Kippen C., Cleveland

FRANKLIN COUNTY
Ehmke, Bruce C., Columbus
Fisher, Rivington H., Columbus
Grover, William L., Columbus
Harold, Frank C., Columbus
Heffelfinger, John Wm., Columbus
Huxtable, Thomas R., Jr., Worthington
Klages, Reynold E., Jr., Columbus
Knisely, Anne M., Columbus
Morley, Buel, Columbus
Schieve, James F., Columbus

FULTON COUNTY
Phillips, Daniel A., Swanton
Vogel, Richard K., Wauseon

GALLIA COUNTY
Brady, Joseph P., Gallipolis
Morgan, Thomas W., Gallipolis

HAMILTON COUNTY
Duffy, John C., Cincinnati
Hess, Emily R., Cincinnati
Minella, Alexander C., Cincinnati
Rosenberg, Louis M., Cincinnati
Sitterson, Beecher W., Mariemont
Stagamen, Joseph H., Military Service
Tenoever, George J., Military Service

HANCOCK COUNTY
Feigert, Marion W., Findlay

LAKE COUNTY
Burham, Maxwell, Painesville
Volk, Myron, Willoughby

LICKING COUNTY
Sinsabaugh, Charles F., Newark

LUCAS COUNTY
Black, David H., Toledo
Green, Marvin C., Toledo
Hanson, Joseph H., Toledo
Shaw, Richard, Toledo
Vallery, Beatrice, Toledo
Wallbank, W. L., Toledo
Zanka, Jaroslov, Toledo

MAHONING COUNTY
Brody, David R., Youngstown
Engstrom, Denton P., Youngstown
Kunin, Kalman C., Youngstown
Peabody, Cary S., Youngstown
Smeltzer, James L., Youngstown
Tornello, Robert L., Youngstown

MARION COUNTY
Sager, Edward T., Marion

MONTGOMERY COUNTY
Ediss, Gerald G., Dayton
Lee, J. Bryon, Dayton
Wells, Phyllis, Dayton

MUSKINGUM COUNTY
Haynes, Earl R., Zanesville

PORTAGE COUNTY
Gebhart, Florence P., Kent

RICHLAND COUNTY
Morkel, Gordon F., Mansfield

SENECA COUNTY
Gaydos, Leonard M., Tiffin
Waite, Richard R., Tiffin

STARK COUNTY
Dowell, Glenn C., Jr., Canton
Tifft, J. George, N. Canton
Tucker, Theodore, Magnolia

SUMMIT COUNTY
Bartholomae, Warren M., Akron
Marsh, William C., Akron
Sand, Richard E., Akron

WAYNE COUNTY
Koss, Frank Robert, Apple Creek

WOOD COUNTY
Fraser, James M., Perrysburg

Ohio Medical Indemnity . . .

1952 Report Shows Ohio Doctor-Sponsored Prepaid Surgical and Medical Coverage Plan Increasing at Rapid Rate; Election of Officers Is Held

ANNUAL meeting of Ohio Medical Indemnity, Inc., Ohio's Blue Shield Plan, sponsored by the Ohio State Medical Association, was held on April 1 in Columbus.

By vote of the stockholders, the following were elected to the Board of Directors: Dr. Robert T. Allison, Jr., Akron; Dr. A. A. Brindley, Toledo; Dr. H. M. Clodfelter, Columbus; Dr. R. Dean Dooley, Dayton; Dr. Charles N. Hoyt, Chillicothe; Dr. James S. Matthews, Wyoming; Dr. Carll S. Mundy, Toledo; Dr. George Sackett, Cleveland; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. Robert G. Smith, Circleville; Dr. Edmond K. Yantes, Wilmington; and Dr. Starling C. Yinger, Springfield; Mr. C. H. Campbell, Columbus; Mr. D. A. Endres, Youngstown; Mr. James B. Fenner, Toledo; Mr. Clair E. Fultz, Columbus; Mr. Edgar W. Jones, Canton; Mr. Charles Mills, Marysville; Mr. Harold W. Slabaugh, Akron; and Mr. David L. Temple, Dayton.

OFFICERS ELECTED

The Board organized by electing the following officers for the ensuing year: President, Dr. L. H. Schriver, Cincinnati; vice-president, Dr. Carll S. Mundy, Toledo; secretary-treasurer, Mr. Charles S. Nelson, Columbus; executive vice-president, Mr. Charles H. Coghlan, Columbus; assistant treasurer, Mr. Frank Van Holte, Columbus.

The following were appointed to the Executive Committee with approval of the Board: Dr. Mundy, chairman, Dr. Allison, Dr. Clodfelter, Dr. Dooley, Dr. Sherburne, Dr. Yantes, Dr. Sackett, Mr. Slabaugh and Mr. Fultz.

A detailed report on the operations and activities of O. M. I. during the past year was presented to the Board by Mr. Coghlan.

STATISTICAL ANALYSIS

Ohio Medical Indemnity, Inc., now has assets of $5,737,878. Since it began business in 1946, the company has paid claims amounting to $7,311,-159. It has a general reserve of $2,813,723 and an obstetrical reserve of $982,650;

The number of claims paid during 1952 was 131,041, an increase of 29,387 over the number of claims paid during 1951.

Of the 128,039 claims paid for surgical and obstetrical procedures, the following figures show the types of surgery and obstetrics for which the highest percentages of claims (by number) were paid: Normal deliveries, 22.23 per cent; tonsillectomies and adenoidectomies, 13.95 per cent; integumentary system (tumors, etc.), 10.95 per cent; fractures, 6.64 per cent; appendectomies, 4.37 per cent; hysterectomies, 3.54 per cent; dilatation and curettage (non-obstetrical), 3.14 per cent; hemorrhoidectomies, 3.02 per cent; and herniotomies, 3.01 per cent; musculoskeletal surgery other than fractures, 2.73; cystoscopies, 2.44 per cent. An additional 26 types of surgery accounted for 23.98 per cent of the number of claims paid. Medical care in hospitals accounted for 3,002 claims.

Of the 7,031,314.50 paid for surgical and obstetrical procedures, the following figures show the percentage of that amount paid for the types of surgery and obstetrics indicated: Normal deliveries, 20.41 per cent; hysterectomies, 9.84 per cent; appendectomies, 8.00 per cent; tonsillectomies and adenoidectomies, 6.98 per cent; fractures, 4.87 per cent; herniotomies, 4.64; abdominal surgery of the digestive system, 4.19; biliary tract, 4.10; integumentary system (tumors, etc.), 3.31 per cent; oophorectomies and salpingectomies, 3.11 per cent; musculoskeletal surgery other than fractures, 2.93 per cent. An additional 26 types of surgical procedure accounted for 27.62 per cent of the amount paid. Medical care in hospitals accounted for $89,329.50.

ENROLLMENT HIGH

Enrollment during 1952 of 257,471 members represented the second highest enrollment in all the seven years of O. M. I. The following table shows the strong growth of the plan during its seven years:

Year	Total Membership	Members Added During Year
1946	71,895	71,895
1947	295,151	213,256
1948	465,267	252,012
1949	658,079	192,812
1950	990,603	332,524
1951	1,157,445	166,842
1952	1,414,916	257,471

With enrollment standing at 1,414,916 as of December 31, 1952, Ohio Medical Indemnity has become the fourth largest Blue Shield plan in the nation, being exceeded only by plans in the states of New York, Michigan and Pennsylvania.

TWO NEW TYPES OF CONTRACT

The year 1952 recorded a particularly significant step in the introduction of the Preferred Contract, providing higher idemnity at higher

premiums, and the Non-Group Contract. Because both of these new contracts were introduced in the latter part of the year, a true picture of development could not be predicted. It is expected, however, that a substantial increase in enrollment will occur in the present year, particularly in the Preferred Contract. This contract should prove to be attractive, Mr. Coghlan pointed out, not only because it provides for more adequate benefits for surgical procedures, but also because it includes for the first time payments for professional anesthesia.

O. S. U. Cancer Research Lab . . .

Dedication of New Building in Health Center Group Will Be Held On Saturday, May 9, Preceded on Friday, May 8, by Cancer Symposium

FORMAL dedication of the new Cancer Research Laboratories of the Ohio State University Health Center will take place on Saturday, May 9, 1953, 10:30 a. m., as a part of the University-wide observance of the annual Alumni Day, Dr. Charles A. Doan, dean of the College of Medicine, announced. The dedicatory exercises will be held in the main lobby of the new University Hospital, to which unit the Cancer Research Laboratories have been constructed as an adjoining five-story north wing.

Representatives of the three groups whose financial support has made possible this new construction; namely, the Legislature of the State of Ohio, the United States Public Health Service, and the Kettering Foundation, will be present to take part in the ceremonies.

An "open house" for inspection of the new facilities will be held both prior to and immediately following the dedication program.

On Friday, May 8, an all-day Cancer Symposium, with invited guest speakers from various cancer research centers in this country, will be held in the Ohio State Museum Auditorium. The program follows:

MORNING SESSION 9:00 A. M.

1. "The Preventive Aspects of Neoplastic Diseases," Dr. Kirk T. Mosley, School of Public Health, University of Oklahoma;

2. "The Role of Nutrition in Cancer," Dr. Albert Tannenbaum, director, Department of Cancer Research, Michael Reese Hospital, Chicago, Ill.;

3. "The Current Experimental Approach and Outlook in Cancer Therapy," Dr. C. P. Rhoads, Director, The Sloan-Kettering Institute for Cancer Research, Memorial Cancer Center, New York City;

4. "The Use of Radioisotopes in Cancer Research," Dr. Paul C. Aebersold, director, Isotopes Division, U. S. Atomic Energy Commission, Oak Ridge, Tenn.;

5. "Studies with Isotope-Labelled Metabolite Antagonists in Cancer," Dr. Howard E. Skipper, assistant director, Southern Research Institute, Birmingham, Ala.;

6. "The Program of the New Argonne Cancer Research Hospital," Dr. Leon O. Jacobson, director Argonne Cancer Research Hospital, University of Chicago School of Medicine, Chicago.

LUNCHEON

Luncheon, 1:00 p. m., Room 329-ABCDE, Ohio Union.

AFTERNOON SESSION 2:30 P. M.

7. "The Problem of Acute Leukemia in Childhood," Dr. Sidney Farber, director of research Children's Cancer Research Foundation, Boston, Mass;

8. "The Management of Benign and Malignant Tumors of the Liver," Dr. George T. Pack, The Pack Medical Group, New York City;

9. "Cancer of the Ovary," Dr. Howard C. Taylor, Jr., professor and chairman, Department of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, and director, Sloan Hospital for Women, New York City;

10. "Progress in the Study of Hodgkin's Disease," Dr. Antonio Rottino, director, Hodgkin's Disease Research Laboratory, St. Vincent's Hospital, New York City.

All physicians are cordially invited to attend these sessions.

Ohio State Medical Alumni To Hold Banquet at A. M. A. Session

The Ohio State University Medical Alumni will hold a banquet in New York at the time of the American Medical Association Annual Meeting there, Dr. Carl A. Lincke, Carrollton, president of the Medical Alumni, announced. The banquet will be held at the Hapsburg House, 313 E. 55th Street, at 7:00 p. m. on Wednesday, June 3.

Reservations may be made through the Alumni House on the Ohio State University Campus, Columbus. Speaker for the occasion will be Dr. Charles A. Doan, dean of the O. S. U. College of Medicine, who will speak on the O. S. U. Health Center and progress being made there.

Nursing Needs in Ohio . . .

Governor's Committee Survey Reveals Interesting Data on Subject: Recommends that Commission Be Established To Make Thorough Study

THE Governor's Committee on Nursing Needs in Ohio, in its report submitted to Governor Frank J. Lausche recently, recommended "that a Commission be established by voluntary agreement or governmental action financed by government or private funds, with a full-time staff and adequate budget, to investigate more exactly the causes of the problem and to test the procedures proposed for solving it."

This Committee, created by Governor Lausche in the spring of 1952, points out that it is unable from data which it was able to collect from various sources to evaluate the extent of underlying factors of the nursing shortage.

In its 22-page report the Committee makes the following summary and recommendations:

EXTENSIVE STUDY WELCOMED

"As the Committee has reviewed its work, it is of the opinion that this is obviously a superficial study. Investigation of the problem assigned has raised more questions than it answers.

"The response from the field indicates that hospital administrators, nursing educators, and nursing service administrators feel the need for a thoroughgoing study of the problem. They have welcomed the present inquiry, been most cooperative and helpful and have made numerous suggestions about problems needing investigation.

"The Committee is unable from the data at hand to evaluate the extent or underlying factors of the nursing shortage. It has found that many factors affect the situation.

"One of the major factors appears to be the increasing demand of the American people for health, medical and nursing care. If this demand continues at the same rate, or increases, the shortage of nursing personnel is likely to become more acute. The rapid development of the hospital construction program, with governmental support, has pointed up the imminence of this development.

RECRUITMENT AND SELECTION

"The committee does not recommend one recruitment procedure over another or establish selection procedures. It suggests that groups engaging in recruitment activities make a community check and use those procedures found most effective in the local situation. Every community has recruitment resources of one type or another which have been successful in time of need. It suggests that the nursing profession endeavor to develop practical selection procedures.

"Consideration should be given to the establishment of schools for the trained practical nurse in the more rural areas of the State.

"The Committee is fully cognizant of the services that can be performed in the care of the sick and injured by trained practical nurses and, therefore, strongly recommends that the Department of Education of the State of Ohio cooperate with local hospitals and the local boards of education to develop programs in the vocational high schools for the training of practical nurses, and that the State appropriate additional funds to the Department of Education to be used by the Vocational Division to meet its share of the expense involved in operating such programs for the training of practical nurses.

"The Committee suggests that strengths and weaknesses in the present programs for nursing education be studied for the purpose of developing a sound plan of action, and for developing procedures for implementation of projected plans. It also suggests that the role of the public school and other tax supported agencies in the education of nursing personnel be studied, and the findings of such a study be used in making further recommendations.

STUDY ON COST

"The Committee suggests that an agreed form be worked out for calculating hospital and nursing costs for use in making a study of hospital expenses and that a complete study of those expenses be made, with particular reference to the costs of nursing services and the costs of current nurse education and training programs.

"The Committee also suggests that a study of the costs of nursing education include the various kinds of schools where nurses are educated, and that efforts to reach common consent about the best way to finance nursing education be attempted when the means of developing the basic data are developed and the present picture more accurately defined.

UTILIZATION

"It is highly desirable that careful and continuous studies of methods, policies and organization be made in order to improve utilization of all classifications of nursing personnel. Obviously the care of the ill and injured does not lend itself to the same degree of impersonal standardization as does the manufacture of inanimate products but norms should be developed against which to measure current practices.

"On the other hand, employment policies

DETAILED REPORTS OF THE 1953 ANNUAL MEETING WILL APPEAR IN THE JUNE ISSUE

Because of the time element, this issue of *The Journal* was made up before the Annual Meeting which took place in Cincinnati, April 21-23. Detailed reports of the meeting, including biographical sketches of new officers, proceedings of the House of Delegates, reports of attendance and other high lights, will appear in the June issue.

should be sufficiently flexible to take full advantage of the contributions that can be made by those persons who can work only at irregular times.

"The Committee recommends that a Commission be established by voluntary agreement or governmental action financed by government or private funds, with a full time staff and adequate budget, to investigate more exactly the causes of the problem and to test the procedures proposed for solving it."

SUPPLY-DEMAND COMPLICATION

Elsewhere in the report, the Committee points out that while there was an increase of 31.8 per cent in the professional nurse population in the decade from 1940 to 1950, there was an increase of 100 per cent in the number of patients admitted to hospitals during the same period. The hospital field is only one in which the demand for nurses has spiraled.

"It is commonly assumed that the crux of the nursing problem is a shortage of personnel," the report states, "although this is difficult to demonstrate. The evidence is largely indirect. Unfilled requests for nursing services for ill persons, and unfilled requests for qualified nurses for teaching, supervision and other services of various kinds in hospitals, schools of nursing, institutions of various types, social agencies, industries and other commercial organizations indicate a lag between the supply of and demand for nursing personnel.

"However, the problem is probably more than a shortage of adequately prepared nurses," the report continues. "It reflects changes in the practice of medicine, social philosophy, standards in education, increases in the number and size of hospitals, as well as changes in the way hospitals are administered, in personnel policies relative to the employment of nurses and other personnel, in hours of work, in the variety of occupational opportunities for nurses, and in the economics of living.

"Many more people are seeking hospital care than in past years," the report goes on. "Hospitalization insurance plans and increased population have been major factors in doubling hospital admissions in the last 12 years. A variety of employment opportunities other than nursing, formerly not available, are now open to persons with nurse's training. In addition, the number of and kinds of employment opportunities open to women show an increase. These are factors contributing to the shortage of personnel."

PERSONNEL OF COMMITTEE

Persons representing approximately 75 organizations interested in the matter responded to the Governor's invitation and met in Columbus on April 17, 1952, to discuss the problem and make plans for meeting it.

As a result of this meeting, Governor Lausche appointed the following committee to study nursing needs in Ohio:

Dr. John D. Porterfield, director of the Ohio Department of Health, chairman; Dr. H. M. Clodfelter, Columbus, president of the Ohio State Medical Association; Helen Bunge, dean of the Western Reserve University School of Nursing; Clyde Hissong, director, Ohio Department of Education; Sister Mary Edith, chairman, State Nurses Board and dean, School of Nursing, St. John's College, Cleveland; Erwin C. Pohlman, superintendent, Grant Hospital, Columbus; George F. Quinn, Cleveland attorney; Mrs. Litta Roberson, Ohio Farm Bureau; Mrs. Clyde C. Shively, Columbus, League of Women Voters. Secretary of the Committee is Miss S. Gertrude Bush, R. N., chief, Division of Nursing, Ohio Department of Health.

Dr. Fleming To High Light Allegheny Society Meeting in Pittsburgh

The Allegheny County Medical Society extends an invitation to members of the Ohio State Medical Association to attend its annual meeting, Wednesday, May 19, at the William Penn Hotel, Pittsburgh, Pa.

The scientific speaker will be Sir Alexander Fleming, discoverer of penicillin. He also will be the after dinner speaker.

Time of the scientific paper will be 4:30 p. m. Dinner will be at 7:00 p. m. Tickets are $8.00 including refreshments. Dinner reservations and hotel reservations should be made with Frederic W. Fagler, executive secretary, the Allegheny County Medical Society, 225 Jenkins Bldg., Pittsburgh 22, Pa.



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SEARLE Research in the Service of Medicine

Immune Globulin . . .

Policy on Allocation for Use in Measles Is Announced by Department Of Health; Committee Is Formulating Policy for Use in Other Fields

ANOTHER step in the development of a full-scale program for the distribution of Ohio's allotment of immune globulin has been concluded by the Advisory Committee to the Ohio Department of Health on Allocation of Immune Globulin. **This step was the issuing of recommendations on usage of immune globulin in the prevention and modification of measles,** which recommendations have been released to *The Journal* by Dr. John D. Porterfield, State director of health, as the prevailing policy pattern of the Ohio Department of Health on this subject.

This is the first in a series of recommendations which will be made by this committee. Additional developments will be reported in *The Journal* as they are announced.

Although a specific program on the allocation of the supply for use in poliomyelitis had not been announced as this issue went to press, a general roundup of the subject by Dr. Porterfield was published in the April issue of *The Journal.* The reader is referred to page 335 of that issue.

All immune globulin is being pooled and distributed through the U. S. Office of Defense Mobilization. The Ohio Department of Health has been designated the agency through which Ohio's allotment will be distributed.

Following are the advisory committee's recommendations on usage in the prevention and modification of measles:

RECOMMENDATIONS

It is recommended that during the period in which immune globulin is in short supply, it be used for the prevention of measles in the following circumstances in the listed order or priority:

1. In children of any age exposed to measles, without a previous history of measles, who are suffering from any acute or chronic pulmonary disease.

2. In children who are hospitalized for other conditions, inadvertently exposed to measles while in the hospital.

3. In children who are convalescing from a recent illness, or in whom for other medical reasons it is desirable to prevent a superimposed febrile illness.

4. In pregnant women during the **first trimester** of pregnancy who are exposed to **German measles** (Rubella). This does not apply to measles (Rubeola).

5. In children over the age of six months, but under the age of three years exposed to measles.

This order of priority was chosen because the committee feels it represents the order of risk of serious complications faced by these various groups when exposed to measles. It should be noted that it is **not** recommended that measles be prevented or modified in exposed children over the age of three years who are in good health. This upper limit of three years was chosen because the vast majority of deaths and serious complications occur in patients below this age. Children under six months of age have in most every case sufficient placentally transferred immunity to protect them.

It is realized that the modification of measles in older exposed children is an accepted and much used procedure. It is strongly recommended, however, in the face of the serious shortage that the available material be utilized for these more urgent situations.

The usually accepted measles prevention dosage is 0.1 cc. per pound of body weight. This should be given six days or less after the day of exposure if at all possible. Injections after the sixth day may have some modifying effect but prevention is not likely to be successful.

The recommended dosage for pregnant women exposed to German measles is 10 cc. This may be given either as one injection, or in two injections of 5 cc. each, five or so days apart.

Membership of advisory committee is Mr. W. K. Dunton, Piqua, Ohio Congress of Parents and Teachers, Inc.; Dr. O. M. Goodloe, Columbus, Local Health Commissioner; Dr. W. W. Lawrence, Norwalk, Local Health Commissioner; Dr. Anthony Ralph Marsicano, Columbus, Ohio Academy of General Practice; Dr. Warren E. Wheeler, Columbus, Pediatric and Poliomyelitis Treatment Center; and Dr. Thomas R. Curran, Columbus, Ohio State Medical Association.

Akron—Dr. Charles A. Dixon was the subject of a feature article in the *Akron Beacon-Journal*, the occasion being the completion of 59 years of practice in the community.

Ashtabula—Dr. Bernard S. Matthews, superintendent of the Cleveland Receiving Hospital, spoke before a meeting of the Ashtabula County Mental Health Association on the subject, "First Aid for the Emotions."

Cincinnati—The National Foundation for Infantile Paralysis has made a $125,000 grant for research to be directed by Dr. Albert B. Sabin at the Children's Hospital Research Foundation, Cincinnati.

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1. Reich, W. J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

1-1648

Golfers' Tournament . . .

Physician Golfers Are Invited to Annual Get-Together and Contest Of Medical Golfers' Association at Elyria Country Club on June 18

THE Elyria Committee of the Ohio State Medical Golfers' Association announces plans for the 1953 Ohio State Medical Golfers' Association annual tournament. Dr. Valloyd Adair is chairman and Dr. Delbert Russell is co-chairman. The date selected for this year's party for the golfing medics of Ohio is Thursday, June 18.

A GOLFER'S DREAM

For sheer beauty, layout and year round condition of fairways and greens, few golf courses anywhere can match what Elyria Country Club has to offer. One hole (No. 15) was selected by Life Magazine for its "dream" course. Fairways are watered. Greens are large and beautifully maintained. The course presents a challenge even to the par shooter, but the beginner and the "duffer" also find it a real pleasure to play.

The club house has fine facilities and every effort is being made by the local committee to assure the O. S. M. G. A. members, new and old, a splendid day of golf and good fellowship.

The Elyria Country Club is located on U. S. 20 between Elyria and Oberlin. Sign cards will be posted at important intersections the day of the golf tournament to guide the visitors.

NEW MEMBERS WELCOME

Any male doctor who is a member in good standing of the Ohio State Medical Association may make application by completing the form at the bottom of this page. An initiation fee of $5.00 which is paid only once, is requested from new applicants. All former members who have played in tournaments during the past seven years will receive notice of further details of the O. S. M. G. A. annual meeting and tournament.

Registration of all doctors who wish to play in this year's tournament should be made at least a week in advance so that the local committee can make the necessary arrangements.

TB Symposium for GP's

The Second Annual Tuberculosis Symposium for General Practitioners will be held in Saranac Lake, New York, from July 13 through 17. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is $40 for A. A. G. P. members and $50 for non-members. Registration is limited to 100 doctors.

Complete information concerning this program can be obtained by writing: Richard P. Bellaire, M. D., Tuberculosis Symposium for General Practitioners, P. O. Box 707, Saranac Lake, New York.

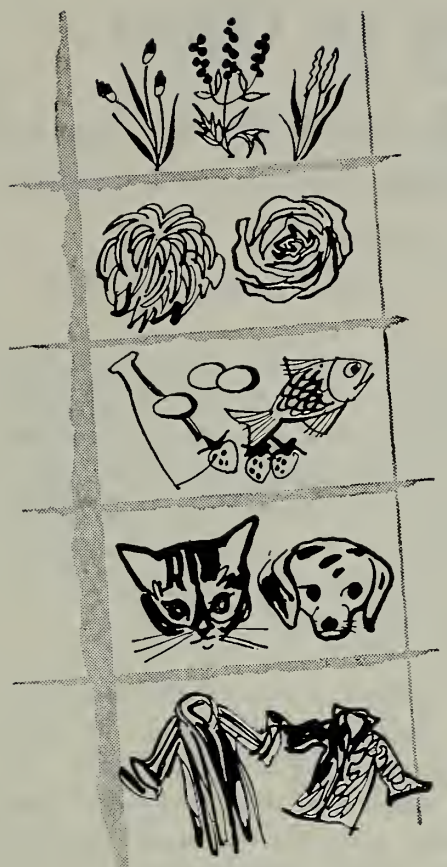
Mail to
Bob Elwell, Secretary and Treasurer
Ohio State Medical Golfers' Association
3101 Collingwood Blvd.
Toledo 10, Ohio

I am a member of O. S. M. G. A. and wish to register for the 1953 tournament. Enclosed is my check for $14.00 to cover green fees, luncheon, banquet and prizes.

I wish to apply for membership in O. S. M. G. A. and register for the 1953 tournament. Enclosed is my check for $19.00 to cover Initiation fee ($5.00), green fees, luncheon, banquet and prizes.

Signed ----------, M. D.

Address ----------



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Physicians' Placement Service in Ohio . . .

Favorable Report of Situation in Ohio Is Made by A.M. A. Council On Medical Service After Careful Study in Office of the O.S.M.A.

A FAVORABLE report on the Physicians' Placement Service carried on by the Ohio State Medical Association was published in the February 21 issue of *The Journal of the A. M. A.* The report is based on an extensive study made when a representative of the Council on Medical Service of the American Medical Association spent considerable time in the Columbus Office of the Ohio State Medical Association.

As the report indicates, the O. S. M. A. Placement Service is primarily threefold: (1) It assists communities in their attempts to attract physicians to their areas; (2) it assists young physicians who are starting out in practice and physicians who wish to relocate to find communities to their liking, and (3) it assists physicians who are looking for associates and assistants or institutions which are seeking services of physicians. As the report further indicates, the State Association indirectly assists communities in fulfilling their needs for physicians through a vigorous Rural Health program and by promotion of medical education in the State.

The report as published in the *A. M. A. Journal* follows:

THE REPORT

Medical services and personnel of the densely populated state of Ohio appear to be adequate in number and properly distributed. Yet there is a need for physicians in the rural areas where human factors, such as the inclination to travel on the part of both physicians and patients, determine the need for medical care.

Ohio is a leader industrially and agriculturally. By and large, the medical needs of the industrialized areas of the state are adequately met through a general tendency for physicians (and all professional men) to concentrate in the more urban areas. This urban trend on the part of medical men does not seem to have an economic basis at the present time.

A physician in the rich rural areas has, generally speaking, the opportunity to enjoy a larger income and attain it earlier than his fellow physician in the large city. Therefore, in dealing with the problem of medical care in rural areas, one must examine the facilities for medical practice and family life that are offered by these smaller communities.

HISTORY OF PLACEMENT ACTIVITIES

For years the Ohio State Medical Association has functioned to match the desires of a physician seeking location with the medical needs of a community.

With the return of physicians from the armed forces after World War II, however, the association found its placement services increasingly in demand. In 1945 and 1946, it began compiling lists of physicians seeking locations and making these lists available to towns in need of physicians. Likewise it made available to physicians a list of openings for practice in Ohio.

It was also at this time that the medical association inherited the records of the physicians procurement and assignment board of the state Selective Service agency. The file cards on each physician in the state used by this board were brought up to date and the material contained therein expanded to the point where, at the present time, the state medical association has a complete file of information on every physician practicing in Ohio. These cards are filed by county and are often referred to by the placement service.

METHOD OF OPERATION OF THE OHIO PHYSICIAN PLACEMENT SERVICE

When a physician requests information concerning openings for practice in Ohio, the letter of inquiry goes to the office of the executive secretary, Mr. Charles Nelson, who acknowledges the letter, answers any specific questions it may contain, and calls attention to towns that are about to lose their physicians to the armed services. With this answering letter is enclosed a list of towns with openings for physicians.

In November, 1951, an additional letter listing communities that were in immediate need of a physician and offered better than average opportunities was sent to the physicians listed as seeking locations.

A card with the physician's name and a résumé of the information included in his original letter is filed separately. This is done so that when a request comes to the office for a particular type of physician, such as a specialist or an assistant, the information is readily obtainable.

When a town or physician writes the association seeking a physician, Mr. Nelson answers the letter, stating he will place the opening on the list of available locations. He encloses in this letter the current list of physicians seeking placement.

When vacant office space is the prime motivation for the request for a physician, the inquiring party is advised that his needs might

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FOR INFORMATION ABOUT THESE AND OTHER COURSES ADDRESS—
THE DEAN, 345 West 50th Street, New York 19, N. Y.

better be served through an advertisement in the state medical journal. In these cases if the need for medical care is seen by Mr. Nelson as genuine, the opening is carried under a miscellaneous listing.

When a physician establishes a practice in Ohio, the medical association office is, as a rule, first informed of this fact through its newspaper clipping service. Often this source also supplies information as to how a town has gone about securing a physician. Other channels by which the association learns of newly located physicians are letters from the men themselves and membership applications from the county medical societies.

Twice a year the men on the lists of physicians seeking locations are checked by mail and the list is revised.

In the spring of 1952, the association submitted to all county medical society secretaries a questionnaire relevant to their current requirements for physician's services. At this time also questionnaires were sent to all industrial concerns, hospitals, and government agencies that had formerly been listed as in need of physicians. Requests for specialists were checked by a third letter. With all this information at hand the new and up-to-date listing of opportunities for physicians was compiled.

DATA ON LISTS OF OPENINGS

At the present time the list of openings as sent to physicians includes the name of the town, its population, in some cases the population of the area, the number of physicians in practice there, and the name of the person to contact in regard to the opening.

Any data on the opening, in addition to the above, are supplied either by the town in its original request letter or from such sources as the state departments of education and health and county summary sheets that give the medical facilities, number of physicians, and the type of practice in each county.

STUDY OF OPENINGS

Often when the list of locations is sent to a physician, Mr. Nelson marks with a red pencil those towns that seem to offer the greatest opportunities for a physician. He bases this appraisal on his personal knowledge of the state, a consideration of the letter of request, the number of physicians in the community recently and the extent of their practice, and any information gained from interview with delegations from that community. In some cases the county medical society secretary is contacted to verify a need in a given locality.

MAINTENANCE OF LISTS OF PHYSICIANS SEEKING LOCATIONS

The name of any physician who writes the state medical association seeking a place to practice is automatically put on the association's list of available physicians. Since many interns and residents in Ohio are from other states, only those men who take the Ohio State Medical Board examination and obtain a license are contacted by mail and invited to use the placement services.

The Ohio state association is planning a questionnaire that will be sent to all physicians requesting the list of openings. This will provide the association with information, some of which will be incorporated into listings of physicians seeking location.

Increasing the Supply of Physicians.—The Ohio State Medical Association actively supported a legislative program for the expansion of the state medical school. Three medical society representatives appeared before the legislature in favor of the appropriation of over eight million dollars for expansion purposes.

The bill as passed represented a joint endeavor sponsored by Senator John Bricker, the medical alumni of Ohio State, and many other groups interested in the state medical school. As a result of this appropriation, the first year enrollment of the medical school has been increased from 88 students in 1948-1949 to 150 per year during the past three years. In addition, the medical school has launched a building program which to date has produced a 600 bed university hospital, a new dental school building, and much expanded medical services for the state.

Promotion of General Practice by Scholarship Programs.—The Rural Health Committee of the state medical association selects each year a young man from a rural area who has been accepted in an Ohio medical school to be the recipient of a $500 yearly scholarship award. There is no obligation other than a moral one encouraging the recipient to settle in a rural area to practice.

Support of Programs to Interest Students in General Practice.—The first series of informal lectures sponsored by the Committee on Rural Health of the state medical association was given to senior medical students at Ohio State University in 1952. The enthusiastic reception these lectures received insures their yearly repetition. It is hoped that the other medical schools in Ohio will incorporate these lectures into their senior programs.

Preceptorship programs have as yet not become a part of the Ohio scene. They are, however, on the agenda of the Rural Health Committee, and at the present time opinion reports on this program are being collected from physicians throughout the state.

Making Rural Practice More Attractive.—By supplying speakers for scientific sessions of the state medical association as well as county medical societies in the Columbus area, the medical school of the University of Ohio maintains an



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CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete) . . . . . 32 Gm.
*CARBOHYDRATE . . . . . 65 Gm.
*LIPIDS . . . . . 30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council

active interest in continuation education programs for medical practitioners. Additional postgraduate instruction is offered to physicians in rural Ohio by the Ohio section of the American Academy of General Practice in cooperation with the state medical school.

The lack of diagnostic laboratory and consultation facilities has discouraged many young physicians from entering rural practice. In Ohio this problem has been met through the operation of the university medical center. By referring patients to this center any physician may have returned to him the results of a diagnostic work-up on the case along with recommendations for further treatment.

ASSISTING COMMUNITIES TO ATTRACT PHYSICIANS

When a community requests help in finding a physician, the Ohio Association will send to that community the A. M. A. pamphlet, "How to Get a Doctor," reprinted from the *Farm Journal* of April, 1951. In regard to small communities that cannot support a physician, the Ohio Association feels duty bound to list as openings every request for a physician. They consider this course wise from a public relations standpoint. Rather than to tell community leaders that they cannot hope to get a resident physician, their reply is, "We will put you on the list but don't be too optimistic for there are other locations with more opportunities for a physician and in greater need of one."

MISCELLANEOUS

The Ohio Rural Health Council was organized as a post World War II project to promote better rural health services and facilities. Its membership includes representatives of such agencies as the Ohio State Medical Association, the Farm Bureau, State Department of Health, and the Ohio Council of Churches and 22 area representatives attached to no particular group. The efforts of this group have done a great deal to dispel the antagonism once directed toward the medical profession in Ohio because of the feeling that the medical care problems of the rural areas were being neglected by the profession.

The rural health council has helped to create a spirit of self-help on the part of rural communities seeking medical service. This council has as its stated objectives: (1)the assembling and dissemination of information to inform rural persons of the health programs being carried out in other counties; (2) the encouragement of organizations and agencies to initiate programs of health education within their own organization; (3) holding Ohio state and district meetings to afford opportunities for lay and professional people to discuss health problems together; (4) training of leaders in rural areas to assume responsibility in promotion of health activity; (5) encouraging counties to make surveys and studies to determine local health problems and needs on which to base programs.

The Clinton County Survey of Medical Needs was made possible as a result of the cooperation of doctors and lay groups acting through the Ohio Rural Health Council.

New Rule On Medical Fees For Care of Old Age Pensioners Issued by Division

A new regulation relating to how physicians shall be paid for services rendered to recipients of aid to the aged residing in institutions or in a household where more than one recipient resides, has been issued by the State Division of Aid for the Aged.

The information contained in the regulation, which reads as follows, is being distributed to practitioners and institutions by local offices of Aid for the Aged:

"If a physician treats more than one individual during the same call in a household or institution, the allowance for such multiple calls will be made only in accordance with the following conditions:

"a. The allowance which may be made for any recipient is: $5.00 for the first call and $2.00 for each subsequent call or patients seen on same call (including ordinary medication and dressings).

"b. The physician shall be expected to keep to a minimum the number of calls on patients having a chronic ailment. In no case will an allowance exceed one call per week, except as provided in Paragraph (c).

"c. If a chronic ailment increases in intensity to such extent that more than one (1) call per week is required for a person living in an institution, an allowance may be made, provided the bills are endorsed by the operator or superintendent as provided in Paragraph (d).

"d. The allowance for treatment of acute ailments shall be based on the actual number of calls required. However, if the patient having such ailment is living in an institution of any type, the bills for such care must carry the signature of the operator or superintendent of the institution, who has called the doctor, before being submitted for payment.

"e. In order to prevent violation of the policy of providing assistance only to the extent needed by the client, the Subdivision Manager may, at his discretion, require that any or all bills submitted for care of a person living in a particular institution be endorsed by the operator or superintendent before being submitted for payment."

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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

THIS IS EVERY PHYSICIAN'S BUSINESS

Rehabilitation is every physician's business, says Dr. Howard A. Rusk, in a piece in *Current Medical Digest*. Rusk points out the increase in life expectancy and that studies indicate that the higher the age group, the greater the percentage of chronic disease and disability.

"The concept of rehabilitation and the basic techniques must be made a part of the armamentarium of all physicians, for regardless of the type of disability, the responsibility of the physician to his patient cannot end when the acute injury or illness has been cared for," Dr. Rusk states. "Medical care is not complete until the patient has been trained to live and to work with what he has left" is his final advice to the medical profession.

Rehabilitation is becoming a live and vital subject in Ohio. A state-wide committee to study the subject and to make recommendations for meeting it has been formed. The medical profession must be in the front lines, individually and collectively. It certainly is every physician's business.

WHAT ABOUT THOSE MEDICAL BILLS?

What about this question of medical bills?

Figures gathered for the Federal Reserve Board by the Survey Research Center of the University of Michigan produced some interesting slants on this subject.

It was revealed that of about 53,000,000 families in the United States, almost 43 million (over 80 per cent) reported no medical debts. If they had been ill, their bills must have been met from cash, insurance or through public assistance.

One million families owed from $200 to $1,000 and 200,000 families reported owing more than $1,000, meaning that less than three per cent appeared to be in real financial difficulty so far as medical expenses were concerned. Some 9 million families listed medical debts varying from $1.00 to $200.

Commenting on this interesting bit of information, the *Saturday Evening Post* points out that "unpaid bills are always bothersome, but it would be interesting to have a comparable analysis of how much people owe corner grocers, department stores or finance companies," and then hurls these barbs at the advocates of socialized medicine:

"The point is, on the facts as shown, 80 per cent of people surveyed have no medical debts at all, while another 17 per cent have medical debts that ought to be entirely manageable within the family budget.

"But, for those who advocate socialized or government or political medicine, it is necessary to turn the problem upside down. The dark side of things is their specialty, and the 3 per cent must be described as the norm, in order to justify the infliction of another expensive bureaucracy on the suffering taxpayer. Any other way of helping the people who really need help is dismissed as half measure.

"This business of reversing any sensible approach to the relations of the people and their government was spotted long ago by Grover Cleveland. That sage remarked that it was the business of the people to support the Government and not of the Government to support the people.

"As far as the medical-debt problem goes, there is nothing in the record to justify any all-out intervention by Washington officials along the lines of the British National Health Service."

FEWER STUDENTS APPLYING TO MEDICAL SCHOOLS

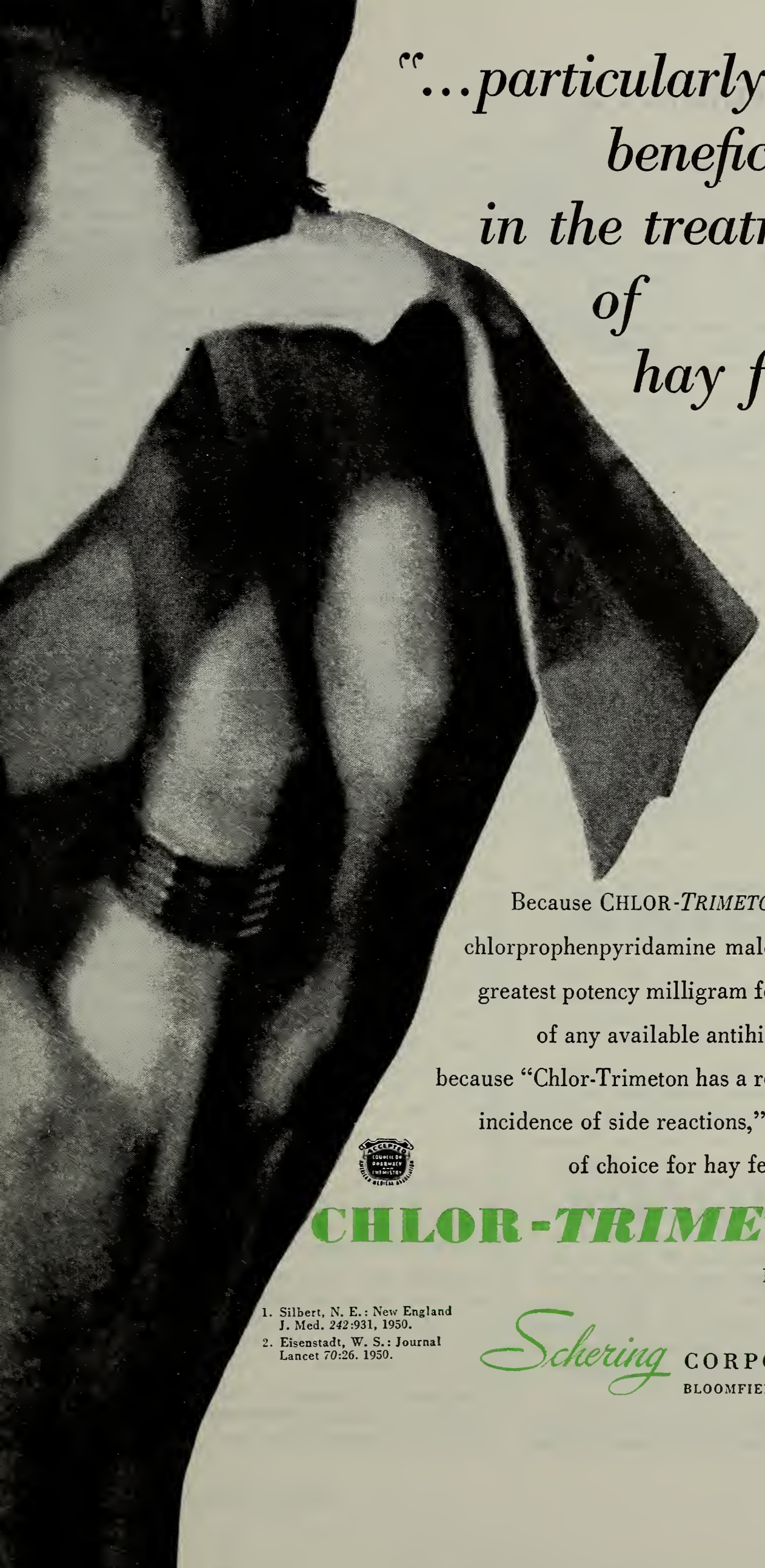
According to the most recent breakdown of statistics by the Association of American Medical Colleges, the number of students applying for admission to the nation's medical schools declined again this year, continuing a three-year trend.

Some 3,150 fewer students applied for admission in 1952-53 than in 1951-52 and some 7,600 less than three years ago. Of 16,763 students who made application last Fall, 7,778 were accepted.

Obviously, this means that competition among the medical schools for high-ranking student applicants is increasing. In fact some schools are finding it difficult to fill their freshman classes with top-bracket students.

Coming at a time when pressure is being exerted on medical schools to expand and enlarge, this trend must be watched. Above all other things, the standards of medical schools must be safeguarded both as to curriculum and caliber of student body.

The West Virginia State Society of Medical Technologists will meet for its fifth annual convention in Charleston, W. Va., on May 22, 23 and 24, at the Daniel Boone Hotel.



"...particularly beneficial in the treatment of hay fever."[1]

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1. Silbert, N. E.: New England J. Med. *242*:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet *70*:26. 1950.

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SCHERING

In Memoriam . . .

Edgar D. Allen, M. D., Crooksville; Starling College, Columbus, 1900; aged 74; died on or about April 12; member of the Ohio State Medical Association; vice-president of the Perry County Medical Society in 1922 and in 1937 and its president in 1925; also active on several county society committees. A practicing physician in his community for more than a half century, Dr. Allen had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. His widow survives.

Isabel A. Bradley, M. D., Wilmington, Pa.; University of Michigan Medical School, 1899; aged 89; died April 7. Dr. Bradley retired in 1945 as assistant superintendent at the Columbus State Hospital after serving many years at that institution. She moved from Ohio to California and about a year ago moved to Pennsylvania.

William C. Cauble, M. D., Akron; University of Louisville School of Medicine, 1901; aged 78; died March 27 after being injured in a traffic accident last September. Dr. Cauble practiced for 24 years in Millersburg before moving to Akron 25 years ago. A veteran of World War I, he was a member of the Veterans of Foreign Wars; also a member of the Masonic Lodge. For many years he had been on the board of the Akron Boxing Commission. His widow and three sisters survive.

Howard L. Green, M. D., Toledo; Toledo Medical College, 1898; aged 81; died December 30; member of the Ohio State Medical Association and member of the American Medical Association; Fellow of the American College of Surgeons. Dr. Green had been a practicing physician for about 55 years and had received the 50-Year Pin and Certificate of the Ohio State Medical Association. Affiliations included memberships in the Baptist Church and the Masonic Lodge. Surviving are his widow and a brother.

Edward E. Hart, M. D., Toledo; Meharry Medical College, Nashville, 1924; aged 55; died February 20; member of the Ohio State Medical Association; member of the American Trudeau Society.

Claude M. Keever, M. D., Marietta; University of Cincinnati College of Medicine, 1896; aged 77; died March 15. Dr. Keever, who practiced for a total of 56 years in Belleville, W. Va., Parkersburg, W. Va., and Belpre, Ohio, was an honorary life member of the West Virginia Medical Association. He was a member of the Christian Church. Surviving are his widow and three sons, one of whom is Dr. Kenneth W. Keever of Magnetic Springs.

Walter Leslie McKinney, M. D., Sidney; Eclectic Medical College, Cincinnati, 1905; aged 80; died March 18; former member of the Ohio State Medical Association, last in 1948. Dr. McKinney practiced in Sidney from 1905 until 1912, when, after doing postgraduate work, he moved to Payne. He returned to Sidney during World War II and continued his practice there. His widow and a son survive.

Denver H. Patterson, M. D., Cleveland; Cleveland-Pulte Medical College, 1901; aged 75; died April 2; member of the Ohio State Medical Association; member of the American Medical Association. A practicing physician in the Collinwood community for all of his professional career, Dr. Patterson had received the 50-Year Pin and Certificate of the Ohio State Medical Association and had been presented an engraved plaque by the citizens of his area. In addition to his professional work, he was active in civic and fraternal affairs. He was a member of the Congregational Church and several Masonic orders. Surviving are his widow, three daughters and a brother.

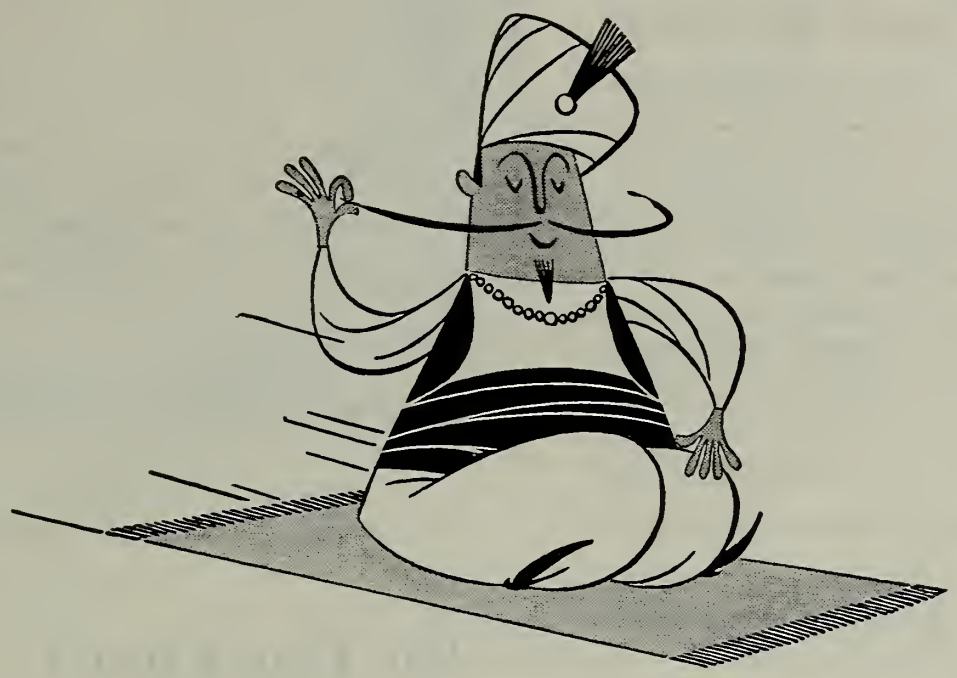
Franklin C. Wagenhals, M. D., Columbus; Johns Hopkins University School of Medicine, 1913; aged 68; died March 15 while in Paris, France; member of the Ohio State Medical Association; member of the American Medical Association; member of the American Psychiatric Association, and diplomate of the American Board of Psychiatry and Neurology. A practicing physician in Columbus for many years, Dr. Wagenhals was emeritus professor of neurology at Ohio State University College of Medicine. He had been clinical associate professor of neurology and psychiatry until his retirement in 1951. Dr. Wagenhals was board chairman of the Wagnalls Memorial at Lithopolis, was active in the Sons of the American Revolution and was a past governor of the Sons of the Colonial Wars.

Mary H. White, M. D., Cleveland; Cleveland-Pulte Medical College, 1898; aged 93; died April 3. Dr. White was a practicing physician for 53 years in Cleveland before she retired in 1951.

Cleveland—Dr. William G. Stover, formerly acting assistant superintendent of the Massillon State Hospital, is now superintendent of the Cleveland State Receiving Hospital.

Danville—Dr. Raymond S. Lord, Fredericktown, was elected president of the Knox County Tuberculosis, and Health Association, to succeed Dr. C. E. Cassaday. Dr. John C. Woodland was elected vice-president.

Defiance—Dr. George L. Boomer spoke before the Defiance Kiwanis Club, where he described problems of medical education.



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Office Public Relations For the Busy Physician

Editor's Note: In order to provide tips for physicians in regard to good Public Relations procedures and practices in their offices, *The Journal* will present from time to time concise articles based on suggestions and recommendations made at A. M. A. Public Relations conferences and on articles published in other medical journals.

The second in the series follows:

REDUCE THAT WAITING TIME

Needless waiting arouses resentment, especially when the scene is the doctor's office and the patient is, or thinks he is in need of immediate attention.

At any rate, nothing can make an uncomfortable patient more miserable than merely cooling his heels in the waiting room.

The patient who presents himself at the doctor's office has made a decision of great importance to him. He has decided to spend his time and money and he is anxious about his condition.

In many instances his time is as valuable as that of the doctor. In most instances he thinks it is.

Smart doctors find ways of reducing waiting time to a minimum. When some delay is unavoidable, the considerate doctor assumes an attitude that prevents a feeling of hostility. He also sees that his receptionist assumes such a correct attitude.

Following is a check list of questions that the physician may wish to apply to his office and procedure. The questions are based on contrasting satisfactory and unsatisfactory conditions and procedures found in physicians' offices.

1. Is the reception room comfortable, neat, and clean?
2. Is sincere concern shown for any discomfort or inconvenience which the delay has given the patient?
3. Is attention given to techniques of scheduling patients? Are they realistic on the basis of time required for various patients and various procedures?
4. Are the members of the office staff handling patients correctly . . . have they read "Winning Ways With Patients," a booklet for Doctor's receptionists, available free from the American Medical Association, 535 North Dearborn St., Chicago?
5. In her telephone technique, does the secretary use her own name, make the patient feel that he is important, and clearly indicate when the doctor will be available?
6. If there is delay, does the secretary express her regret and explain how sorry the doctor is that he is causing the patient to be inconvenienced?
7. When a patient arrives at the office, is he greeted personally as soon as possible?
8. If an excessively long wait is indicated by a significant emergency, is the patient given the opportunity of returning at a more convenient time? Is he made to feel that he is playing a humanitarian role by cheerfully relinquishing his appointment?
9. Is appropriate reading material available in the waiting room, to help make the time seem shorter?
10. Does your receptionist minimize fear and boost morale by a cheerful attitude?

Do You Know? . . .

Two grants amounting to more than $19,000 have been awarded the Western Reserve University School of Medicine for heart disease research by the Life Insurance Medical Research Fund. Dr. Normand L. Hoerr will direct research on capillary circulation and Dr. Walter Heymann, on causes and treatment of the nephrotic syndrome.

* * *

The University of Cincinnati College of Medicine has received a grant of $9,700 from the Damon Runyon Memorial Fund for research on cancer of the digestive tract. The work will be directed by Dr. Leon Schiff.

* * *

The final clinical report on the extensive field tests on the use of gamma globulin in the prevention of paralytic poliomyelitis by Dr. Hammon and his associates appeared in the April 11 issue of *The Journal of the A. M. A.*, page 1272.

* * *

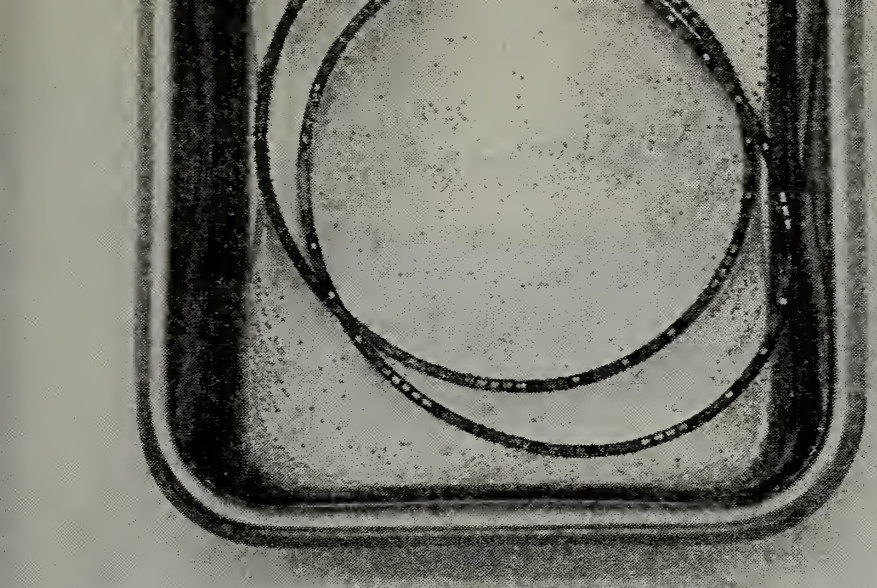
Dr. John D. Porterfield, director of the Ohio Department of Health, Columbus, has been named to the advisory committee of the National Foundation for Infantile Paralysis.

* * *

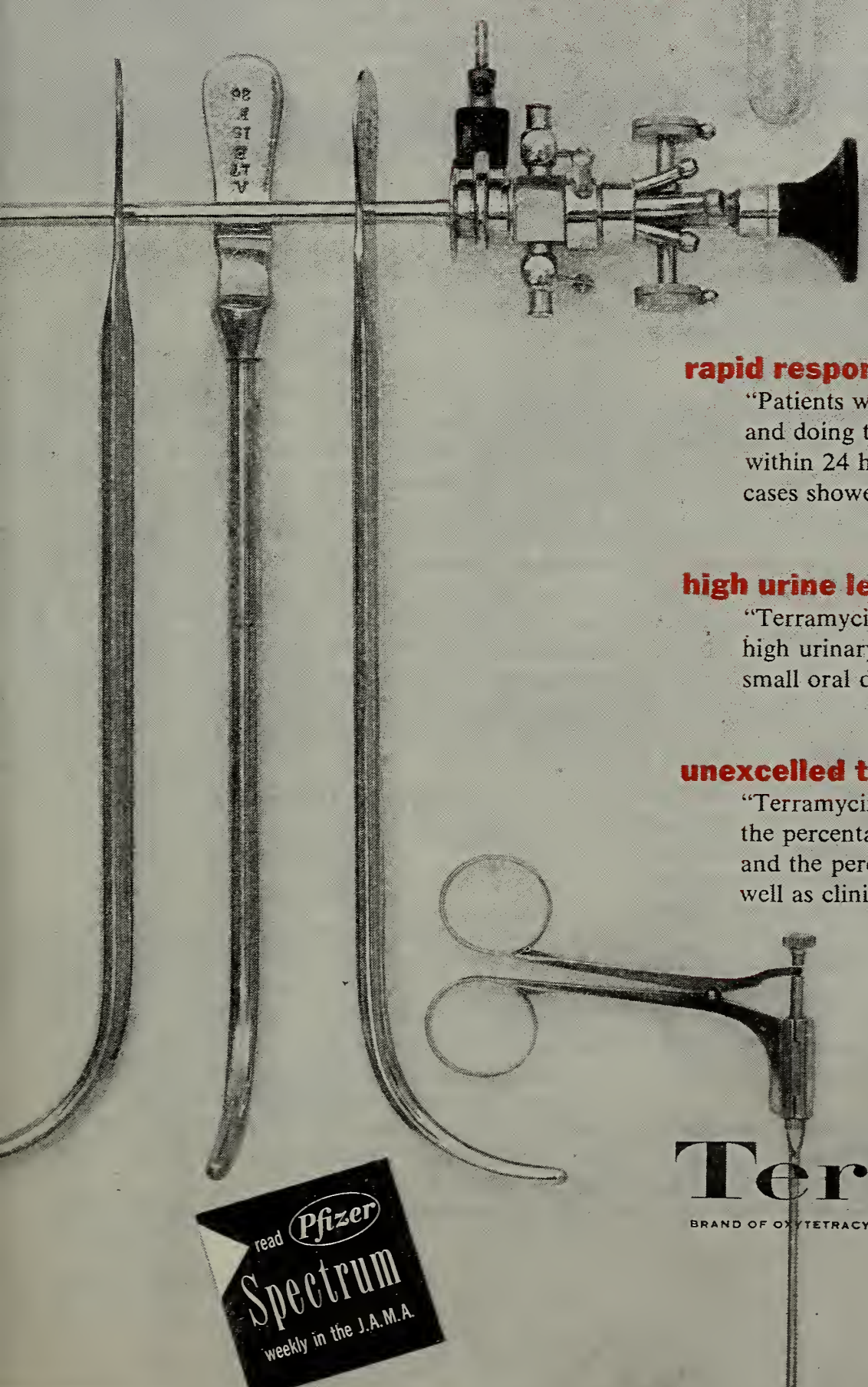
Dr. Charles H. Hendricks, assistant professor in the Department of Obstetrics and Gynecology, Ohio State University College of Medicine, has been appointed chairman of the Medical Advisory Board to the Planned Parenthood League of Ohio. He succeeds Dr. William C. Weir, Cleveland.

* * *

Dr. Donald G. Anderson, Chicago, secretary of the American Medical Association's Council on Medical Education and Hospitals, will relinquish that position on October 1 to become dean of the University of Rochester School of Medicine and Dentistry, Rochester, N. Y.



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1. Canad. M. A. J. 66:151 (Feb.) 1952.
2. J. Urol. 67:762 (May) 1952.
3. Ibid. 69:315 (Feb.) 1953.

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read Pfizer Spectrum weekly in the J.A.M.A.

Activities of County Societies . . .

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CHAMPAIGN

Dr. E. R. Earle was awarded the 50-Year Pin and Certificate of the Ohio State Medical Association at a meeting of the Champaign County Medical Society on April 11. The award was presented by Dr. Merril D. Prugh, Dayton, Councilor of the Second District of the Association.

Dr. Earle graduated from the University of Louisville Medical College and began his practice in Paducah, Ky. In 1910 he moved to Urbana and has practiced there since.

DARKE

Dr. S. N. Maimon, Dayton, spoke on the subject, "Infectious Hepatitis," at the February 17 dinner meeting of the Darke County Medical Society in Greenville.

GREENE

Members of the Greene County Medical Society were hosts to physicians from Fayette, Clinton and Highland County Medical Societies on March 11. The program featured a discussion on "Chest and Heart Diseases in Children," by Dr. Fred Silverman and Dr. Samuel Kaplan, members of the staff of Children's Hospital, Cincinnati.

The Greene County Medical Society met on April 9 at the Greene Memorial Hospital Xenia, and heard a discussion on the subject, "Autonomic Nervous System," by John Lancey, Ph. D., Antioch College, Yellow Springs.

MIAMI

Dr. Warren E. Wheeler, professor of pediatrics and bacteriology, Ohio State University College of Medicine, Columbus, was guest speaker at the April 3 dinner meeting of the Miami County Medical Society at the Stouder Hospital, Troy. His subject was "Management of Diarrhoeas in Infants."

MONTGOMERY

The subject, "Diagnosis and Treatment of Ovarian Tumors," was discussed by Dr. Howard C. Taylor, Jr., professor of obstetrics and gynecology, Columbia University College of Physicians and Surgeons on March 20 at the Miami Valley Hospital. The program was sponsored by the Dayton Obstetrical and Gynecological Society and the meeting included that organization, the Montgomery County Medical Society and the staffs of College Hill Hospital, Good Samaritan Hospital, Miami Valley Hospital and St. Elizabeth Hospital.

"Medical Application of Atomic Energy and Its Products" was the subject discussed by Dr. Charles L. Dunham, chief of the Medical Branch, U. S. Atomic Energy Commission, at the April 3 meeting of the Montgomery County Medical Society in Dayton.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

The following features were included in the March program of the Academy of Medicine of Toledo and Lucas County:

March 6, General Meeting—A panel discussion by the Professional Relations Committee on the subject, "Professional Relations and the Academy."

March 13, Specialties Section—"Urine as a continuation of the extracellular ground substance," Dr. Arthur Butt, director, Butt Memorial Foundation, Pensacola, Fla.

March 20, Pathology Section—"Simple Laboratory Tests of Aid in the Management of Sterility," Dr. David H. Black, associate pathologist at Flower and St. Luke's Hospitals, Toledo.

March 27, Surgical Section.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

LAKE

On April 21 the Lake County Medical Society instituted a new procedure on its monthly meetings. The Society meetings started at 4:30 p. m. with a discussion by Rex Mason, director of Lake County Civil Defense. At 6 p. m. a dinner was held at the Lake County Memorial Hospital, followed at 7:00 o'clock by a meeting of the Hospital staff members. Speakers for that meeting were Dr. William Weir and Dr. William E. Forsythe who discussed "The Study of Infertility," with illustrations by lantern slides.

The foregoing streamlined procedure will be followed in the future, Dr. F. J. Dineen, announced.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

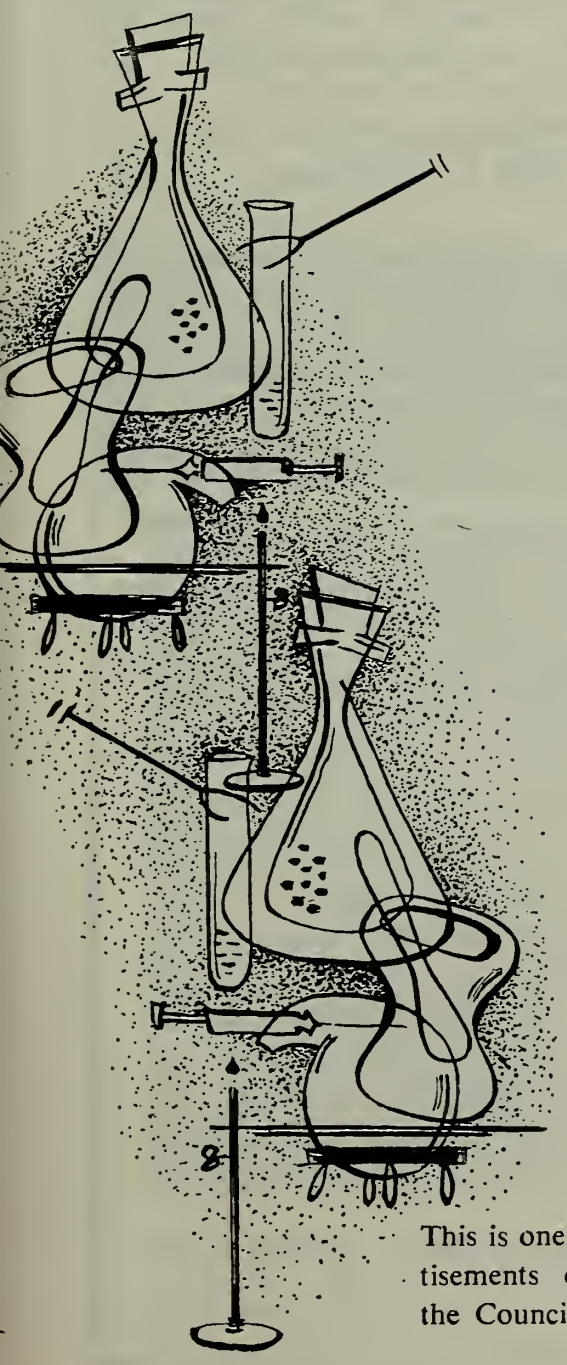
MAHONING

A combined clinic and program on cardiovascular diseases was presented on February 17 by the Mahoning County Medical Society, the Youngstown Area Heart Association and the Mahoning Academy of General Practice.

Guest speakers were Dr. Charles C. Wolferth, emeritus professor of medicine, and Dr. Mary Miller Wolferth, associate in medicine, both of the University of Pennsylvania School of Medicine.

Clinics were held at the Youngstown Hospital,

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South Side Unit, and at St. Elizabeth Hospital, beginning at 11:00 a. m. At 3:00 p. m. conferences were held with interns and residents of all hospitals.

Dinner was held at the Youngstown Club followed by a talk at the Elks Club by Dr. Wolferth on the subject, "Some Problems in the Diagnosis and Treatment of the Hypertensive Patient."

The use of radioisotope tracers in biological material, was the subject discussed at the March 17 meeting of the Society at the Elks Club, Youngstown. Speaker was Dr. K. E. Corrigan, of the Harper Hospital, Detroit, Mich. He traced the history of the use of isotope tracers in medicine, the theory of their use and practical application in medical research today.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

The Belmont County Medical Society met for a program on March 19 at the Bellaire City Hospital. Dr. A. J. Antalis presented two case histories—"Ruptured Esophageal Ulcer," and "Spontaneous Pneumothorax." Dr. Daniel W. Dickson, Wheeling Clinic, spoke on the subject, "Chest Emergencies."

TUSCARAWAS

A dinner party was given at Bonvechio's Restaurant on March 11 for members of the Tuscarawas County Medical Society and their office assistants.

At the April meeting, Dr. G. N. Wenger, Massillon, spoke on the subject of diseases of the rectal cavity.

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

GUERNSEY

Dr. M. S. Lawrence, Quaker City, was honored by his colleagues in the Guernsey County Medical Society at the April 2 meeting in the Berwich Hotel, Cambridge. He was presented the 50-Year Pin and Certificate of the Ohio State Medical Association.

Dr. Robert S. Martin, Zanesville, Eighth District Councilor for the Association, made the presentation, while Dr. George F. Swan was principal speaker for the occasion. Dr. Howard Van Noate, president of the Society, presided at the meeting.

FRANKLIN

The subject, "Training in Natural Childbirth," was discussed at the March 16 meeting of the Columbus Academy of Medicine by Dr. Paul E. Molumphy, assistant professor of Obstetrics and Gynecology, Yale University School of Medicine.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

RICHLAND

Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association, spoke concerning the "State of the Society" at the March 19 meeting of the Richland County Medical Society. Approximately 50 members met at Mansfield General Hospital where dinner was served followed by the business meeting.

National League for Nursing To Meet in Cleveland

The first convention of the National League for Nursing, to be held in Cleveland, June 22-26, will feature many panel discussions, symposia and round table meetings of special interest to all those concerned with nursing education.

Dr. Alan Gregg, vice-chairman of the Rockefeller Foundation, will give the keynote address on the subject, "The Opportunities Before Us."

Registration is $5 for National League for Nursing members, $6 for non-members and $1 for student nurses. Additional information about the convention may be obtained from the National League for Nursing, 2 Park Ave., New York 16. Advance registration will end May 16.

If you are moving to a new location or for other reason plan to change your address, please notify the Headquarters Office as early as possible so that your copy of *The Journal* and other mail may be sent to you without delay.

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GYNECOLOGY—Intensive Course, two weeks, starting June 15. Vaginal Approach to Pelvic Surgery, one week, starting June 8.

OBSTETRICS—Intensive Course, two weeks, starting June 8.

PEDIATRICS—Congenital Heart Disease, two weeks, starting May 18. Cerebral Palsy, two weeks, starting June 15.

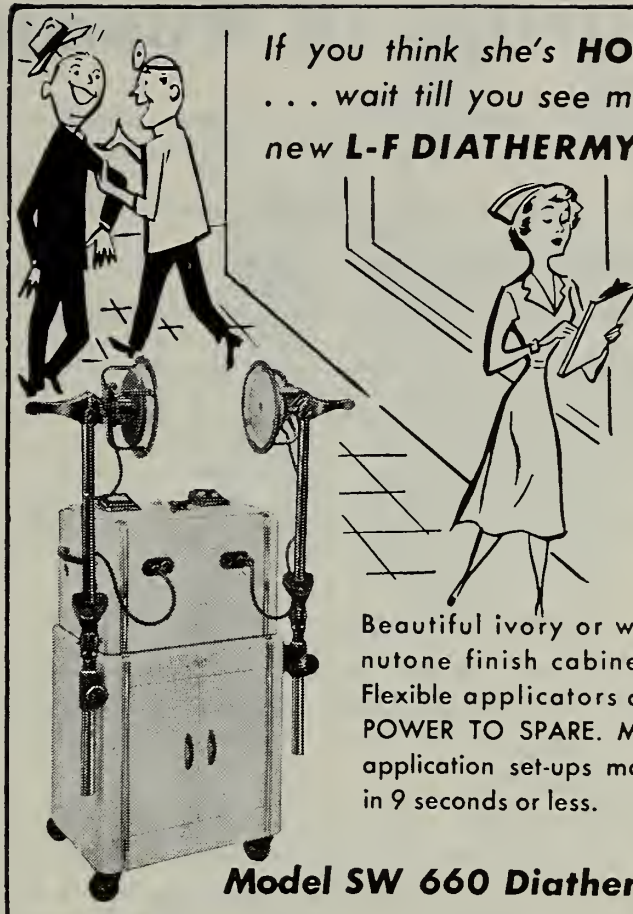
MEDICINE—Gastroenterology, two weeks, starting May 18. Electrocardiography & Heart Disease, two weeks, starting July 13. Allergy, one month and six months, by appointment.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

DERMATOLOGY—Intensive Course, two weeks, starting May 11.

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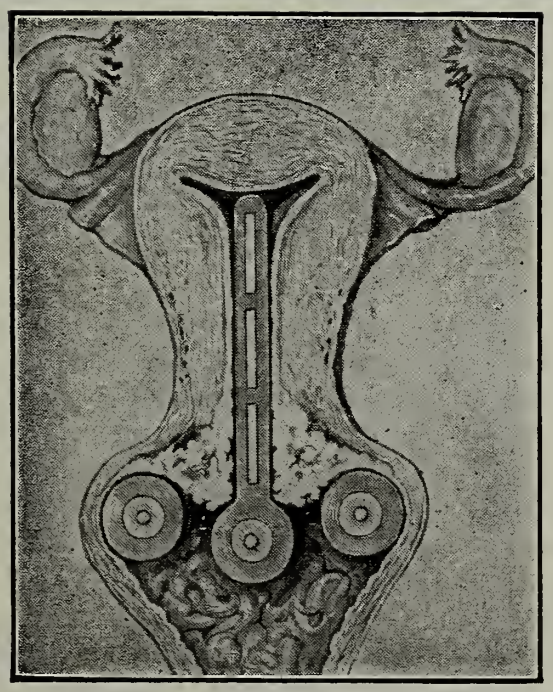
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Activities of Woman's Auxiliary . . .

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President—Mrs. Paul Woodward, 1500 Hollywood Avenue, Cincinnati

President-Elect—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

Vice-President—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. Gaston Hannah, 180 E. Sharon Ave., Glendale

Treasurer—Mrs. C. E. Cassaday, 1106 Vine St., Mount Vernon

Past-President—Mrs. Farrell T. Gallagher, 1527 W. Clifton Blvd., Lakewood

NATIONAL AUXILIARY CONVENTION

The thirtieth annual meeting of the Woman's Auxiliary to the American Medical Association will be held at the Hotel Statler, New York, June 1 to 5, 1953.

Registration and committee meetings will be held on Sunday, May 31. Round table discussions, a Board of Directors luncheon-meeting, and a tea honoring Mrs. Ralph B. Eusden, president, and Mrs. Leo J. Schaefer, president-elect, are scheduled for Monday, June 1.

The formal opening of the annual meeting will take place at 9:00 A. M., Tuesday, June 2, with His Eminence Francis Cardinal Spellman, Archbishop of New York, giving the invocation. Mrs. Eusden will address the delegates, officers will give their annual reports, and the national directors will be presented. Among the six directors will be Mrs. E. Benjamin Gillette, Toledo.

At the general session on Wednesday, June 3, Mrs. N. M. Reiff, president of the Woman's Auxiliary to the Ohio State Medical Association, will present the state report.

The annual dinner for members, husbands and guests will be held at the Hotel Waldorf Astoria on Thursday, June 4. Guest speaker will be The Honorable Mrs. Ivy B. Priest, Treasurer of the United States.

The convention will close following a conference of national officers, directors and committee chairmen with state presidents and president-elect on Friday, June 5.

Ohio Auxiliary members serving on national committees during the past year include Mrs. George W. Cooperrider, Columbus, Bulletin Chairman of North Central District; and Mrs. Roswell Fidler, Columbus, Legislative Chairman of North Central District.

A. M. E. F. FUND

Contributions to the American Medical Education Foundation have been received from the following additional counties: Auglaize, Lake, Shelby, Cuyahoga, Darke, Loraine, Logan, Tuscarawas, and Fairfield. To date 42 counties have contributed a total of $2,001.00 to the fund.

ALLEN

The Woman's Auxiliary to the Lima and Allen County Academy of Medicine met at the home of Mrs. W. E. Yingling on March 24. Guest speaker was R. H. McDonald, investment broker, whose topic was "How to Lay a Nest Egg."

AUGLAIZE

Auglaize County Auxiliary met on March 18 in the home of Mrs. Gordon Miles of St. Marys. After the business meeting, a topic from *Today's Health* entitled "Antivivisection Threatens You" was reviewed by Mrs. T. H. Will.

BUTLER

Mrs. G. E. Marr, president, gave the annual report listing the achievements of the Woman's Auxiliary to the Butler County Medical Society at a luncheon meeting in the Hamilton City Club on March 25. Mrs. Joseph Hufschmitt was chairman of the meeting.

CHAMPAIGN

Mrs. F. E. Lowry and Mrs. I. Miller reported on the School Health Conference at a luncheon meeting of Champaign County Auxiliary held in Millner's Colonial Room on April 6. Mrs. A. B. Ream, chairman of the nominating committee, presented the following slate of officers: Mrs. Lowry, president; Mrs. Miller, president-elect; Mrs. David H. Moore, vice-president; Mrs. John Polsley, secretary-treasurer; Mrs. V. G. Wolfe, historian.

DELAWARE

Mrs. E. J. Marsh, 10th district director, was a guest of the Delaware County Auxiliary at the March 10 meeting held at the home of Mrs. E. C. Jenkins. Mrs. George Blydenburg announced the progress of the Heart Fund drive. Mrs. E. V. Arnold discussed the merits of *Today's Health*. Plans were made for the nurse recruitment tea on April 14. A review of *The Witness*, by Whittaker Chambers, was presented by Mrs. James Parker.

ERIE

Officers were elected at the luncheon meeting of Erie County Auxiliary held at the Business Women's Club on April 6. To be installed at the May meeting are Mrs. Lester G. Parker, president; Mrs. D. R. Lehrer, president-elect; Mrs. Harold Snedden, vice-president; Mrs. W. P. Skirball, secretary; and Mrs. H. F. Kesinger, treasurer. Mrs. G. A. Stimson spoke on "A Trip to the Caribbean."

A hospital book truck, in operation at Good Samaritan Hospital for the past year, will be duplicated at Providence Hospital when the building program is completed. The mobile library was donated by the Erie County Medical Society to the Auxiliary. Magazines are collected twice

weekly and distributed by Auxiliary members as a free service to patients.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine met for dinner on March 16 at the Maramor Restaurant. Mrs. Wiley Forman arranged the program and introduced Miss Bernice A. Warner who spoke on "Nature Underfoot." Mrs. J. E. Van DeWater was chairman of arrangements, assisted by members of the social, program and hospitality committees.

HAMILTON

Dr. Robert A. Lyon spoke on "The Help We Need in Our Baby Clinics" at the annual luncheon meeting of the Woman's Auxiliary to the Hamilton County Medical Society held on March 17 at the Losantiville Country Club. The choral group of the Auxiliary, under the direction of Mrs. Charles F. Sherrick, presented a musical program following the business meeting. Mrs. Daniel Jones was accompanist, and Mrs. John D. Marioni is the chairman of the group.

Young women interested in practical nursing can receive financial help during their year of training at East Vocational High School. To date, 36 students have been aided by a student aid fund established by the Woman's Auxiliary to the Hamilton County Medical Society, the Woman's Club and the Altrusa Club.

HURON

Huron County Auxiliary met on March 13 at the home of Mrs. Charles Edel, Norwalk. Mrs. F. B. Western gave a report on *Today's Health* subscriptions. A legislation report was given by Mrs. W. H. Kauffman. Schools in the county are to be notified that the Auxiliary has $200.00 available to loan to students interested in nursing.

KNOX

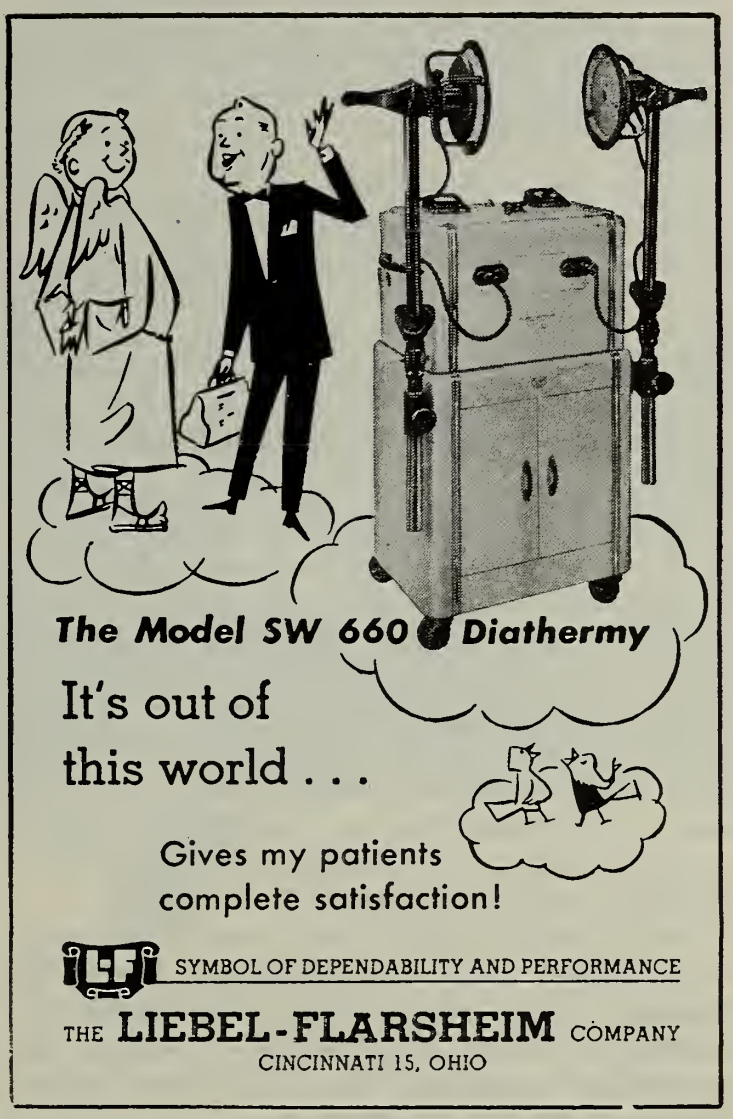
Party night was observed by the Knox County Auxiliary at the home of Mrs. Gordon Pumphrey on March 25, with seventeen members and twenty doctors present.

Each member was asked to secure five donors for the Red Cross bloodmobile women's day on April 28. Mrs. John C. Drake, Mrs. C. E. Cassaday and Mrs. John Baube were named to serve on the nominating committee. John Scott and Donald Weston gave instructions and distibuted literature for the Ground Observers civil air defense.

LAWRENCE

Mrs. W. F. Marting was hostess to members of Lawrence County Auxiliary on February 16. Plans were made to entertain the wives of doctors attending the General Practitioners meeting on March 5. Mrs. William French presented a review from *Today's Health.*

The March 16 meeting was held at the home of Mrs. Thomas Miller. Final plans for the nurse



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recruitment field trip, to be held April 15, were made. Mrs. Marting presented a legislative report on the national and state health programs that are being developed.

LICKING

Honoring the ten high school seniors who applied for the $300.00 nursing scholarship, members of the Auxiliary to the Licking County Medical Society were hostesses at a tea in the Newark Library on March 31. A number of nurses from Newark Hospital were invited to meet the girls and to answer questions.

LOGAN

Logan County Auxiliary met in March for a covered dish luncheon at the home of Mrs. F. W. Kaylor. The group voted to contribute $25.00 to the American Medical Education Foundation. Mrs. John B. Traul was appointed chairman of a committee to designate a suitable project for the Auxiliary. Plans were made for a tea and tour of Mary Rutan Hospital for senior high school girls interested in nursing as a career. Tentative plans were discussed relative to establishing a nurses' loan fund.

The following officers were elected: president, Mrs. Warren Mills; president-elect, Mrs. C. H. Thompson; vice-president, Mrs. John Maurer; recording secretary, Mrs. George Freetage; corresponding secretary, Mrs. A. J. McCracken; treasurer, Mrs. C. K. Startzman.

Mrs. Thomas O'Connor presented an entertaining review of Mary Bard's "The Doctor Wears Three Faces."

LORAIN

Work of the Lorain County Guidance Center in Elyria was outlined by Charles A. Martin, psychologist, to members of Lorain County Auxiliary at a luncheon meeting on March 19 at the Elyria Country Club.

Mrs. Theodore Finegan was elected president, and Mrs. A. J. Novello, president-elect. Other new officers are Mrs. Gerald Krupp, vice-president; Mrs. Roy Hayes, recording secretary; Mrs. Conrad Rusin, corresponding secretary; and Mrs. Norman Basinger, treasurer.

The Auxiliary voted to sponsor the training of a practical nurse at the Central School of Practical Nursing, Cleveland. A donation of $300.00 was made to Pleasant View Sanatorium for the purchase of ceramic supplies for patients.

LUCAS

Dr. Warren Hall spoke on "Sanitation and Housing" at the March 17 luncheon meeting of the Lucas County Auxiliary. Mrs. E. Benjamin Gillette, a director of the Woman's Auxiliary to the American Medical Association, introduced Mrs. Paul Woodward, state president, who spoke of the importance of extending local nurse recruitment programs. Other guests honored were Mrs. W. R. Gibson, director of the 4th district;

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Mrs. A. Paul Hancuff, state vice-president; and Mrs. James E. Mullen, state publicity chairman. A nominating committee was elected, composed of the following members: Mrs. Hazen Hauman, chairman; Mrs. C. J. A. Paule, Mrs. Norman Muhme, Mrs. Bernhard Steinberg and Mrs. Hancuff.

The Mental Hygiene study group met on March 24 at the home of Mrs. William Phillips. Ralph Bridgman, counselor for the Lucas County Court of Domestic Relations, spoke on "Marriage and Its Problems."

Mrs. Myron Means, president, conducted a Board meeting in the Academy Building on April 1.

The Live Issues of Today afternoon study group met at the home of Mrs. Herbert C. Weller on April 1. The subject for discussion was "Formosa." The evening group met on April 10 at the home of Mrs. Ralph Zucker. "North Africa" was the topic.

Twelve members are enrolled in the Canteen Course being taught at the Academy Building by Mrs. Carl Dryer, Auxiliary member, and Mrs. Catherine Cox of the Red Cross staff.

Mrs. Boni Petcoff, president-elect; Mrs. Fred M. Douglass, Sr., chairman of public relations; and Mrs. Rollin Kuebbeler, radio and visual education chairman; have been named by the Board to help with any Auxiliary participation in the Sesquicentennial program.

MAHONING

About 250 high school girls were entertained at a nurse recruitment tea by members of the Mahoning County Auxiliary on March 17 at the Tod Nurses Home. Miss Muriel Dunlap, director of nursing education of Youngstown Hospital, conducted the girls on a tour of the hospital and the nurses' home and explained the details of nursing service to the prospective nurses.

Mrs. W. O. Mermis, president, entertained members of the Board at a luncheon in her home on April 6. Plans for the annual dinner and installation of new officers were discussed.

MIAMI

Mrs. Don Deeter of Troy was chosen president of the Woman's Auxiliary to the Miami Medical Society at the March meeting. Plans were completed for a benefit dance on April 11 to raise money for the nurse scholarship fund.

RICHLAND

Mrs. Paul A. Blackstone was elected president of the Richland County Auxiliary at the April 6 meeting held at the Women's Club. Mrs. Robert W. Walford was named president-elect; Mrs. Karl T. Langacher, vice-president; Mrs. P. O. Staker, recording secretary; Mrs. Robert Pierce, corresponding secretary; and Mrs. Paul J. Lee, treasurer.

Mrs. Albert Voegele, president, appointed Mrs

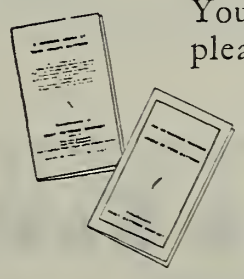


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Blackstone and Mrs. Joseph Siebert to represent the Auxiliary at the city-wide session for community planning.

ROSS

Mrs. Nicholas H. Holmes was elected president of the Woman's Auxiliary to the Ross County Academy of Medicine at a luncheon meeting on April 2. Other new officers are Mrs. G. Howard Wood, vice-president; Mrs. Ross M. Bleak, secretary; and Mrs. James W. Long, treasurer.

Mrs. R. P. Giesler outlined final arrangements for the nurse recruitment tea to be held on April 18.

SANDUSKY

Mrs. Richard Wilson was hostess to members of Sandusky County Auxiliary on March 24. Guest speaker was Judge Robert Gabel who talked on the functions of probate court and the problems of juvenile delinquency. At the business meeting, it was agreed to give a donation to Red Cross. Mrs. John Monahan, president, appointed Mrs. W. J. Martin and Mrs. Lee Moore to serve on the nominating committee.

STARK

Seventy members and guests of Stark County Auxiliary met for luncheon on Feb. 3 at the Canton Woman's Club. Mrs. Ronald Harner was chairman and Mrs. Leslie Lawrence, co-chairman, of the luncheon committee. Mrs. Martin Schmid reviewed Frederick Lewis Allen's "The Big Change." Mrs. Homer I. Keck presided at a meeting of the Board preceding the luncheon.

Cooperating with the Tri-County Nurse Recruitment Committee (Stark, Wayne and Tuscarawas counties) during Nurse Recruitment Week, members of Stark County Auxiliary furnished refreshments and served as hostesses to freshman high school students following the program at Massillon City Hospital on Feb. 12 and at Mercy Hospital, Canton, on Feb. 13. The film "Girls in White" was shown at both meetings, and was also shown at local theaters throughout Nurse Recruitment Week.

Mrs. Homer I. Keck of the Auxiliary served as chairman of the movie-tea program, assisted by Mrs. Leo Schirack, representing the Tri-County Student Nurse Recruitment Committee. The tea program was a new event in the nurse recruitment program this year and was a volunteer effort of the Stark County Auxiliary.

More than 200 members and guests of the Woman's Auxiliary to the Stark County Medical Society were present March 10 for the effective presentation of John Steinbeck's novelet "Burning Bright" by a group of members of Canton Player's Guild.

Mrs. J. S. Feingold was chairman and Mrs.



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C. B. King, co-chairman, of the program arrangements.

SUMMIT

"Better Living Through Better Health" was the theme of the sixth annual Health Days Exposition sponsored by the Auxiliary to the Summit County Medical Society and held at the M. O'Neil Co. Auditorium, February 20 to 23. More than 40 health and welfare agencies had exhibits, including the Dairy Council, the City Water Department, Goodwill Industries. Free chest x-rays, blood typing and blood pressure checks were offered. Mrs. Hubert Senne was chairman of the project, assisted by Mrs. E. L. Voke, president, and a large committee of Auxiliary members.

Arthur H. Kruse, former executive director of Akron's Council of Social Agencies, addressed the March 3 meeting of the Auxiliary held in City Hospital Nurses Home. Mr. Kruse, who now serves as executive director of Family Service, Cleveland, spoke on "Community Planning for the Aged."

Members of the Auxiliary were guests of the Medical Society at a meeting on April 8 at Knight Hall on the Akron University campus. Dr. Donald A. Covalt, associate professor in the Department of Physical Medicine and Rehabilitation, New York University College of Medicine, spoke on "Rehabilitation of the Patient with Hemiplegia."

TRUMBULL

Trumbull County Auxiliary met for luncheon at the Trumbull Country Club in February. Mrs. Morton Crow, general chairman of the Gardenia Ball, gave the final report. Delegates were chosen to represent the Auxiliary at the annual convention. An excellent report on legislation was given by Mrs. J. R. Willoughby, Jr. Mrs. Allen Beale reported the distribution of 100 plastic hearts for the Heart Fund drive.

Mrs. Frank LaCamera introduced the speaker, Mrs. Harold Muter, chairman of the Nurse Recruitment program for Trumbull Memorial Hospital. The Auxiliary voted to help with the scholarship funds, the recruitment program and the teas.

Trumbull County Auxiliary held its March luncheon meeting at the Squaw Creek Country Club. A check was sent to the United Hospital Campaign Fund with the proceeds of the annual Gardenia Ball. After the business meeting, the members made bandages for the local Cancer Society.

More than 4,000,000 people yearly are injured in home accidents severely enough to keep them from their regular activities for one day or longer. At least 100,000 are permanently disabled from the same cause, and 28,000 die as a result of home accidents.—*Metropolitan Life.*

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A. M. A. Annual Session . . .

New York Meeting Will Draw Hundreds of Ohioans June 1-5; Many Ohio Physicians Are Scheduled on Comprehensive Program

APPROXIMATELY 60 Ohio physicians are on the program of the 102nd Annual Meeting of the American Medical Association scheduled in New York City, Monday-Friday, June 1-5. Many Ohio doctors are on the program to present papers, others are scheduled to lead discussions and still others will have scientific exhibits.

High light of the meeting will be the inauguration of Dr. Edward J. McCormick, Toledo, as the incoming President of the A. M. A. The inaugural Meeting will be held in the Grand Ballroom of the Commodore Hotel, Tuesday evening, June 2.

Complete program for the meeting appeared in the April 11 issue of *The Journal of the A. M. A.* The program gives subjects to be presented, names of those taking part, details on section meetings, list of scientific and technical exhibits and many other facts.

Registration headquarters will be located on the first floor, Lexington Avenue entrance of Grand Central Palace. Those who may register are members of the A. M. A. — active, affiliate, associate, service and honorary—and invited guests. Residents, interns, students, nurses and technicians should bring with them a card or letter signed by the superintendent of the hospital where they are registered, or the dean of the medical school they attend.

Hotel reservation blanks have been appearing in current issues of *The Journal of the A. M. A.*

The House of Delegates will meet at the Waldorf-Astoria Hotel. General scientific meetings will be held in the Commodore Hotel, while specialty group meetings will be in various other meeting places. Meetings of the Woman's Auxiliary will be in the Hotel Statler. Scientific and Technical Exhibits will be in the Grand Central Palace.

The American Medical Golfing Association will hold its 37th tournament on Monday, June 1, at the Swianoy Golf Club in Bronxville. Bob Elwell, executive secretary of the Toledo Academy of Medicine, 3101 Collingwood Blvd., Toledo 10, is secretary of the Golfing Association.

The 20th Exhibit of the American Physicians Art Association will be a feature of the meeting.

A. M. A. MEETING TO BE AIRED ON RADIO AND TV

Physicians who cannot attend the A. M. A.'s 102nd annual convention can see and hear highlights of the meeting via radio and television.

The presidential inaugural ceremony will be broadcast coast to coast on Wednesday, June 3. Although the inauguration of President-Elect Edward J. McCormick will be held Tuesday, the coronation of Queen Elizabeth II of England on the same day—which will be widely covered by radio and television—has made it necessary to re-broadcast the proceedings on Wednesday evening.

In television areas, the half-hour "March of Medicine" program, originating at the Scientific Exhibit in New York's Grand Central Palace, will be presented either Thursday or Friday evening. This television coverage will be sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

Further information on these two programs will be available in the near future.

Former Medical Officers Surveyed By A. M. A. Council

In analyzing 467 questionnaires returned by former armed forces medical officers, the Council on National Emergency Medical Service has extracted pertinent data on percentage of time spent in treatment of military personnel and their dependents, staffing conditions and the number of physicians willing to remain in service.

The survey of former army, navy and air force physicians shows:

(1) **Percentage of time:** Between 44 per cent and 54 per cent of total overseas time was spent in treatment of military personnel and between 39 per cent and 53 per cent of total domestic time. Treatment of dependents took between 19 per cent and 28 per cent of overseas time and between 25 per cent and 44 per cent of domestic time.

(2) **Staffing conditions:** Overstaffing—136 replies—ranged from 15 per cent to 44 per cent. Understaffing—79 replies—ranged from 15 per cent to 28 per cent, Adequate—227 replies—ranged from 42 per cent to 58 per cent.

(3) **Willing to stay in service:** 214 replied yes; 236 no.

The Council will continue to send out questionnaires to physicians as they return to civilian life.

A revised list of medical and health films has been prepared by the A. M. A.'s Committee on Medical Motion Pictures. Brief descriptions, running time, and rules and regulations are included in the catalog for 78 medical films which are available from the Committee. Copies of the list may be obtained from the Committee.

Columbus Academy Expels Member

At a meeting of the Columbus Academy of Medicine on April 13, the Academy expelled Dr. Harold J. Wilson, Columbus, from membership by approving a report of the Council of the Academy which had tried Dr. Wilson on charges of violating the provisions of the Constitution and By-Laws of the Academy.

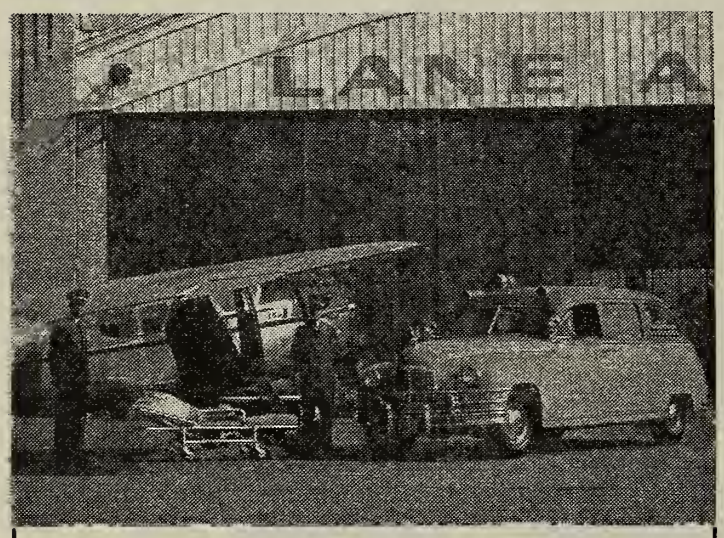
Cardiac Therapy Course

Ohio physicians are invited to attend a post-graduate course in Recent Advances in Cardiac Therapy, to be sponsored by the Kanawha Medical Society on September 16 in Charleston, W. Va.

Dr. R. W. Kissane, Columbus, will be one of the speakers for the occasion. Others on the program include Dr. Charles P. Bailey, Philadelphia; Dr. Ralph E. Dolkart, Chicago; Dr. Edward S. Orgain, Durham, N. C.; and Dr. Francis F. Rosenbaum, Milwaukee, Wisc.

Additional information may be obtained from Dr. I. E. Buff, 310 Atlas Bldg., Charleston 1, W. Va.

More and more medical meetings are being held at the American Medical Association headquarters building in Chicago. One of the staff members compiled a list of meetings held in the building during 1952 and the total number including employee meetings was nearly 100.



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MODERN ONE-STORY BRICK medical office and apartment combination, recently completed. Has automatic gas heat, air conditioning, terrazzo flooring, acoustic ceilings. Rental with option to buy, or direct sale optional. Located in Luckey, 20 minutes driving time from hospitals in Bowling Green and Toledo. Prosperous agricultural and industrial community. Civic club project. Write: Mr. Fred Chambers, Luckey, Ohio.

FOR SALE: Morrow, Ohio; attractive building suitable for a home-office combination. Rural county, unopposed territory. Leaving to study specialty. Box 723, Ohio State Medical Journal.

WANTED: Thoroughly-qualified physician for general practice and industrial work. 200 Republic Bldg., Cleveland, Ohio.

PEDIATRICIAN URGENTLY NEEDED, 1 or 2 years training, Northeastern Ohio County, 75,000 population without pediatrician at present. Area wide open, and people specialist conscious. Can secure help for finance of home and office, no immediate investment actually needed. Welcome as independent or assistant until established. Can guarantee good income, limited only by your desire and ability to work. Above all, community urgently needs your service. Box 734, Ohio State Medical Journal.

U. S. Veteran Population Approaches 20 Millions

The average age of Uncle Sam's nearly 20,000,000 living veterans in civil life is almost 38 years. But the extremes range from 111 years for the oldest Civil War veteran down to under 18 years for the youngest Korean war vet.

These figures were announced by Veterans Administration, based on the estimated age distribution of veterans in civil life as of December 31, 1952.

Following is a breakdown by war, showing the number of veterans of each war and their average age:

Since Korea, 1,483,000 veterans, average age 26.

World War II, 15,424,000 veterans, average age age 34.

World War I, 3,345,000 veterans, average age 59.

Spanish - American War, 95,000 veterans, average age 76.

Indian Wars, 295 veterans, average age 87.

Civil War, 2 Union Army veterans, one 106 and the other 111 years old.

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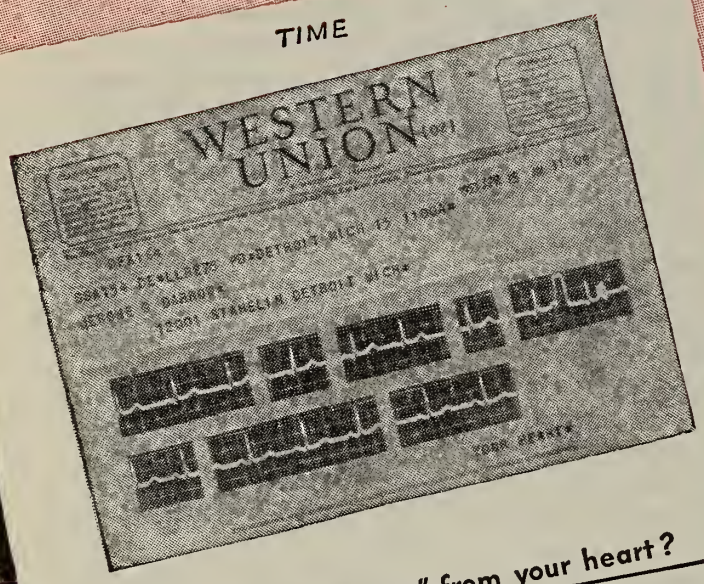




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When interpreted by your doctor, such "telegrams" may read: "Patient's heart normal no need for worry." Others may say: "Patient's heart faulty help required."

Yet, even when the heart sends out a message of trouble, it does not necessarily mean impending tragedy. For even a defective heart is capable of working for years if not overburdened.

Thousands of people are living good lives with bad hearts because they acted wisely and in time.

First, they did not ignore the warnings that often precede heart trouble—*shortness of breath, pains in the chest, irregular beating of the heart, and constant fatigue.* They heeded these warnings in time knowing that their greatest security depended on taking *prompt* advantage of the help which medical science could give them.

Second, they accepted the limitations and restrictions imposed by a weakened heart. They tried not to "over-do", they learned to avoid sudden exertion, and to keep weight at the normal level. They also recognized the value of sleep and relaxation, and the importance of freeing their lives from worry and strain.

Remember that in your physician's hands, you are in good hands. For today, physicians are better equipped than ever before to treat and control heart disease—and to guard against it as well. By taking advantage of the help your doctor can give you now, you increase your chances of living a good life with a bad heart.

Research groups from the National Heart Institute, the American Heart Association, scores of universities, hospitals, pharmaceutical companies, public and private agencies are constantly seeking new knowledge which will help physicians to control heart disease with ever greater effectiveness. Parke, Davis & Company, as a maker of medicines prescribed by physicians, is proud to play its part in this great concerted effort, for it is because of such unrelenting research that there is indeed "new hope for hearts" today.

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SATURDAY EVENING POST



This man is his own worst enemy! Yet most of us can sympathize with him—for most of us don't "run to the doctor" every time we have an ache or pain.

We're much more likely to say: "Oh, I'm all right. It's really nothing." Or to tell ourselves "I'm too busy haven't time to bother with doctors."

Yet, the man (or woman) who ignores seemingly minor symptoms often runs the risk of inviting much more serious ailments. That's because most diseases thrive on neglect: the worst thing we can do is to ignore warning symptoms until it may be too late for the doctor to help.

Medical research in America today is writing one of the most heart-warming chapters in the story of mankind. Our great laboratories, our hospitals, universities, and a host of governmental and private organizations are cooperating as never before to improve our chances of living a longer, healthier life.

Your own doctor has at his disposal all of the discoveries, all of the knowledge, of modern medical science. But you are the only one who can put these vast resources to work to help you.

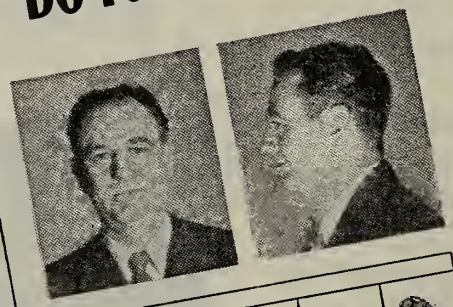
So next time you are tempted to ignore warning symptoms, remember that your greatest danger lies in neglect and delay. Remember—in your physician's hands, you're in good hands. But only by acting promptly can you take advantage of the help he can give you now.

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LIFE

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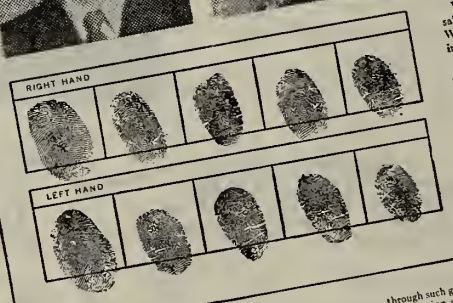
Here's a description of the culprit:

Overweight. Short of breath. (The old ticker really pounds on a flight of stairs.)

Often over-exercises on week-ends after a sedentary week. Sometimes bothered by a peculiar swelling in the ankles.

Works too hard. (Feels he's indispensable in his job.) Has trouble relaxing. Worries. Sleeps poorly. Complains of being "always tired."

Had a couple of attacks of "indigestion" recently. When asked by wife to please check with doctor, was heard to reply: "What for? I'm not sick besides I'm too busy!"



The greatest problem in dealing with heart disease today is the man (or woman) who ignores the "danger signals" until it may be too late to take advantage of the help which medical science today is prepared to give. Yet thousands of people are living good lives with bad hearts, because they acted wisely and in time, because they knew that in their physicians' hands they were in good hands.

For it is a fact that much progress has already been made in dealing with heart ailments, and more and more research is being carried on, largely through such great agencies as the American Heart Association and its nation-wide chapters, the National Heart Institute, and a number of pharmaceutical companies, including Parke, Davis & Company, since 1866 makers of medicines prescribed by physicians.

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*Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943.

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DARKE—Emmett W. Arnold, President, New Madison; Maurice M. Kane, Secretary, Greenville. 3rd Tuesday,

GREENE—S. C. Ellis, President, Xenia; Charlotte Ames, Secretary, Xenia. 2nd Thursday, monthly.
lotte Ames, Secretary. Xenia. 2nd Thursday, monthly.

MIAMI—Hugh Wellmeier, President, Piqua; G. A. Woodhouse, Secretary, Pleasant Hill. 1st Friday, monthly, except Aug. and Sept.

MONTGOMERY—Robert C. Austin, President, Dayton; Mr. Robert F. Freeman, Executive Secretary, Fidelity Medical Bldg., Dayton. 1st Friday, monthly, except July, Aug., Sept.

PREBLE—A. L. Ross, President, West Alexandria; Joseph R. Williams, Secretary, Eaton. No regular meeting date.

SHELBY—John Kerrigan, President, Sidney; George Schroer, Secretary, Sidney. 2nd Tuesday, monthly.

THIRD DISTRICT

ALLEN—William V. Parent, President, Lima; Lawrence N. Irvin, Secretary, Lima. 3rd Tuesday, monthly.

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FRANKLIN—Robert C. Kirk, President, Columbus; Mr. Stanley R. Mauck, Executive Secretary, 79 E. State St., Columbus. 3rd Monday.

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MORROW—Stanley L. Brody, President, Cardington; David James Hickson, Secretary, Mt. Gilead. 4th Tuesday.

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ROSS—Francis W. Nusbaum, President, Chillicothe; Charles N. Hoyt, Secretary, Chillicothe. 1st Thursday, monthly.

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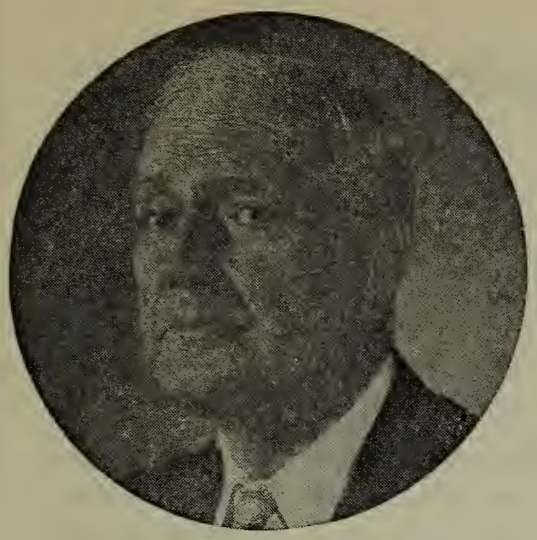
HURON—H. A. Erlenbach, President, New London; Frederick B. Western, Secretary, New London. 2nd Wednesday March, June, September, December.

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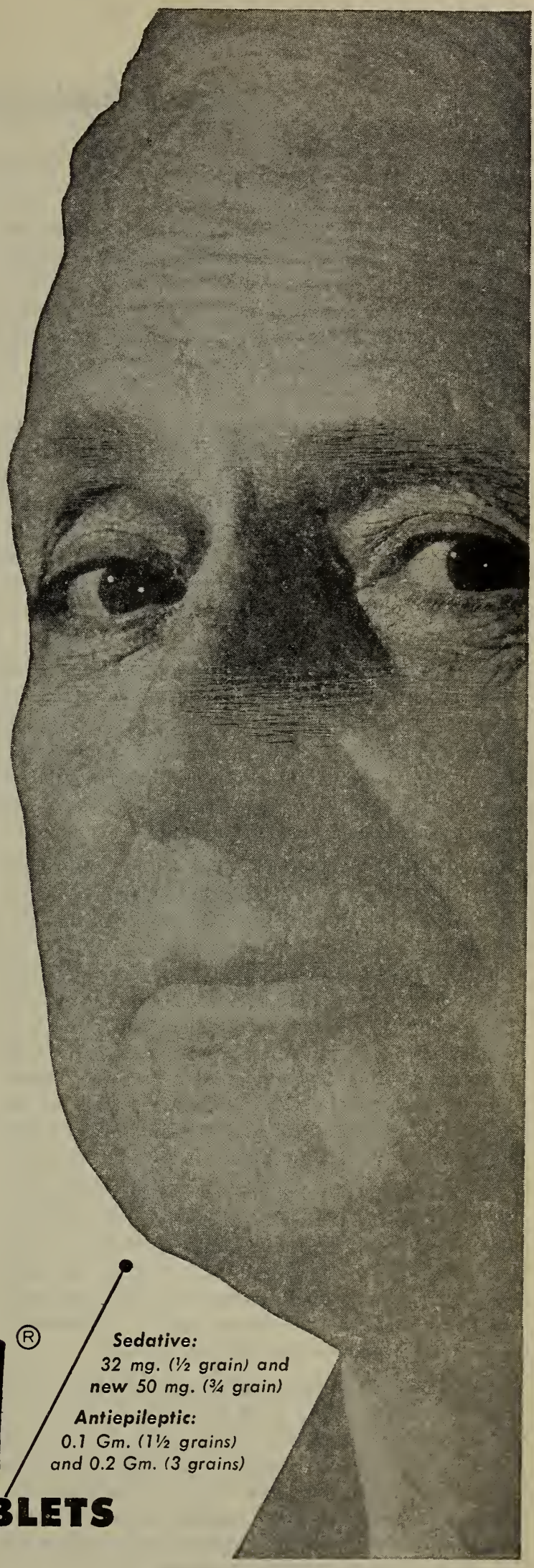
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Who is Guilty?—A Study of Education and Crime, by David Abrahamsen, M. D., ($5.00. *Rinehart & Company, New York, N. Y.).* Here an outstanding psychiatrist brings together all of the available information on crime and tells what society, the home and the school can do about it.

Head First for Health, by Calvin Cottam, ($3.00. *House-Warven, Publishers, Hollywood 27, Calif),* introduces a new concept of bad health which its inventor calls "Craniopathy." The discoverer and author is a graduate in art. His experience consists of an instructorship at the David Seabury School in Therapy Through Art, and as an enlisted man in the Medical Corps of the U. S. A.

Morbus Alzheimer and Morbus Pick, by Torsten Sjögren, Hakon Sjögren and Ake G. H. Lindgren, ($1.00. *Dept. of Psychiatry, Karolinska Institutet Medical School, University of Stockholm, Stockholm),* a genetic, clinical, and pathoanatomical study of the relatively diffuse and the circumscribed cerebral atrophy.

Ophthalmic Pathology—An Atlas and Textbook, by Jonas S. Friedenwald, Helenor Campbell Wilder, A. Edward Maumenee, T. E. Sanders, John E. L. Keyes, Michael J. Hogan, W. C. and Ella U. Owens with editorial assistance of Helen Knight Steward, ($18.00. *W. B. Saunders Co., Philadelphia 5, Penna.),* published under the joint sponsorship of the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology, is based on the collection of pathologic material in the American Registry of Pathology made in the last 30 years.

Diseases of Metabolism, edited by Garfield G. Duncan, M. D., ($15.00. 3rd edition, *W. B. Saunders Company, Philadelphia 5, Penna.),* with contributions by a staff of authorities. It gives detailed methods of diagnosis and accepted treatment for nearly 1200 large pages. A standard reference properly brought up to date.

Viral and Rickettsial Infections of Man, edited by Thomas M. Rivers, M. D., ($7.50. *J. B. Lippincott Company, Philadelphia, Penna.).* Presents 39 chapters by an authority on that particular phase of the subject and includes the diagnosis, prognosis, and current choice of treatments—a well rounded clinical guide of the various diseases coming under this heading.

Essentials of Body Mechanics In Health and Disease, by Joel E. Goldthwait, M. D., Lloyd T. Brown, M. D., Loring T. Swain, M. D., and John G. Kuhns, M. D., ($6.00. 5th edition. *J. B. Lippincott Company, Philadelphia, Penna.)* Increasing numbers of injuries in industry, in traffic and in war have made it worth while to restudy rehabilitation. This text has been highly regarded and has been completely revised.

Practical Dermatology for Medical Students, by George M. Lewis, M. D., ($7.50. *W. B. Saunders Company, Philadelphia 5, Penna.),* is also an excellent guide for the physician not specializing in skin diseases. Concise, well illustrated, with emphasis upon diagnosis and management.

P-Q-R-S-T—A Guide to Electrocardiogram Interpretation, by Joseph E. F. Riseman, M. D., ($4.00. 3rd edition. *Macmillan Company, New York 11, N. Y.),* is intended for the beginner, to be used as a practical guide during the actual examination and interpretation of electrocardiographic tracings. Although it differs from the usual text in form, it serves its own purpose admirably. It is arranged so as to make possible the analysis of an unknown tracing in order to arrive at an electrocardiographic diagnosis.

Nutrition and Diet in Health and Disease, by James S. McLester, M. D., and William J. Darby, M. D., ($10.00. 6th edition. *W. B. Saunders Company, Philadelphia 5, Penna.).* With the addition of a junior author and a completely reset text, this is in fact a new book. Vitamin B_{12}, the trace minerals, the rice diet, the new dietary equivalents in planning of diabetic diets are just some of the new things.

Medical Biographies—The Ailments of Thirty Three Persons, by Philip Marshall Dale, M. D., ($4.00. *University of Oklahoma Press, Norman, Oklahoma),* is designed to appeal directly to the layman in an attempt to illuminate a dark corner of legitimate biography, in a few selected instances, with the light of modern medical understanding. From the possible rupture of the duodenum ulcer of Buddha, to the tuberculosis of Robert Louis Stevenson and the sugar in the urine of William McKinley.

The Pharmaceutical Curriculum, by Lloyd E. Blauch and George L. Webster, ($2.00. *American Council on Education, Washington 6, D. C.),* is the report prepared for the committee on curriculum of the American Association of the College of Pharmacy.

You and Your Doctor, by Martin Gumpert, M. D., ($3.00. *Bobbs-Merrill Company, Indianapolis 7, Indiana),* is a guide to modern medicine showing the reader how to be a good doctor's

good patient. It is done in an unusually clear fashion, making understanding easy.

The Literature on Streptomycin—1944-1952, (revised edition), by Selman A. Waksman, ($5.00. *Rutgers University Press, New Brunswick, N. J.)*, contains 5550 references on the subject and is therefore a valuable book of reference.

Diseases of the Heart and Arteries, by George R. Herrmann, M. D., ($12.50. Fourth edition. *C. V. Mosby Company, St. Louis 3, Mo.)*, represents primarily the experience of this distinguished cardiologist in the application of the fundamental discoveries as they have been reported during the three and one-half decades. A most useful volume.

The Principal Nervous Pathways, by Andrew Theodore Rasmussen, Ph. D., ($4.50. *MacMillan Company, New York 11, N. Y.)*. In this fourth edition the professor of neurology at Northwestern has presented the results of years of planning to help students get a fairly accurate knowledge of these pathways.

Logan Turner's Diseases of the Nose, Throat, and Ear, edited by Douglas Guthrie, ($8.00. Fifth Edition. *Williams & Wilkins Co., Baltimore 2, Maryland)*, is a revival of a work which has held an important place in the literature of the specialty by a group of Edinburgh otolaryngologists. It gives the basic essentials in some 475 pages. A good working text.

The Prenatal Origin of Behavior, by Davenport Hooker, Ph. D., Sc. D., ($2.50. *University of Kansas Press, Lawrence, Kansas.* Porter Lectures, Series 18). The head of the Department of Anatomy in the University of Pittsburgh has gathered together the available evidence including his own work that indicates that the behavior of vertebrates, including man, has in beginning in the early exteroceptive responses exhibited in embryonic and fetal life.

Child Psychotherapy, by Samuel Richard Slavson, ($4.50. *Columbia University Press, New York 27, N. Y.)*. Here a well known authority on analytical and group psychotherapy presents a complete picture of the growing child; how maladjustments may occur in child development and how they may be corrected.

Operative Neurosurgery, With Emphasis on Procedures in Trauma, by Elisha Stephens Gurdjian, M. D., and John E. Webster, M. D., ($10.00. *Williams & Wilkins Company, Baltimore 2, Maryland)*, places special emphasis on the procedures in traumatic cases. It nevertheless covers the whole field. It is 85 per cent technique and 15 per cent diagnosis. The illustrations are all helpful. The work is well planned and adequately carried out.

The Knee and Related Structures—Injuries, Deformities, Diseases and Disabilities, by Philip Lewin, M. D., ($16.00. *Lea & Febiger, Philadelphia 6, Pa.)*, has been written by a man who is known to all of us as a student, a gleaner of the literature, a seeker after truth and one who has for years been a busy and successful orthopedic surgeon. This makes it a must for surgeons in the field and book of reference for the rest of us.

Vision With Spatial Inversion, by F. W. Snyder and Nicholas Henry Pronko, ($2.00. *University of Wichita Press, Box 1953, Wichita, Kansas)*. From their experimental data, the authors infer that perception does not exist at birth but that it comes into being only as the result of a series of contacts between the organism and features of its environment. They also suggest that a radical revision of present-day theories of perception is in order.

Normal Blood Pressure and Hypertension—New Definitions, by Arthur M. Master, M. D., Charles I. Garfield, M. D., and Max B. Walters, M. D., ($4.00. *Lea & Febiger, Philadelphia 6, Pa.)*. We are surprised when we come to think of it that our concepts of normal blood pressure are based upon the findings of life insurance companies in a selected group of persons and an analysis of their mortality. So we have arbitrarily classified each of our patients with a pressure of 150/95 as hypertensive. This the authors point out has been a great mistake and has in many instances caused hardships. The new limits of normal blood pressure proposed by the authors must in all instances be correlated with the case. It may be normal or it may be abnormal, depending upon its correlation with the other factors in the case.

Hemifacial Spasm, a Clinical and Pathophysiological study, by Robert Wartenberg, M. D., ($4.00. *Oxford University Press, New York 11, N. Y.)*, presenting a rare but mighty important problem (especially to the victim) is a model of clinical exposition. In it we learn all there is to know and get a bold and original attempt of attacking the problem of management.

Rypins' Medical Licensure Examinations, edited by Walter L. Bierring, M. D., ($8.00. Seventh Edition. *J. B. Lippincott Company, Philadelphia, Penna.)*. Here a panel of seven distinguished medical teachers have selected and prepared authoritative information in such a way as to make it serve appropriately for study in preparation for all types of examination.

Infrared Photography in Medicine, by Leo C. Massopust, Sr., ($2.75. *C. C. Thomas, Springfield, Ill.)*. A review of the results of this type of photography in the field of medicine and its advantages in photographing certain wet specimens and in the delineation of blood vessels. A book for the library of everyone called upon to photograph pathological specimens.

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Improving the Rate of Cure in Cervical Carcinoma

ALLAN C. BARNES, M. D., and CHARLES H. HENDRICKS, M. D.

THE medical profession enters 1953 with the unhappy knowledge that during the next 12 months 25,000 women will die of cancer of the reproductive tract. And if such knowledge is the wormwood, the bitter gall is the companion fact that approximately 20,000 of them could have been saved—saved by weapons which are already a part of our medical armentarium.

It is of considerable importance, therefore, periodically to review those weapons which will lower the mortality in cervical cancer. Such a review is not a discussion of more extensive operative procedures for tissue excision, nor of stronger gamma rays for tissue destruction; neither pelvic exenteration nor any form of irradiation can save the life of even 10 per cent of the women with Clinical Stage IV cervical carcinoma. Rather it constitutes a careful resurvey of those methods by which the diagnosis can be established before the cancer has reached Clinical Stage IV; established while it is still confined to the cervix, and the word "cure" may be used with some degree of legitimacy.

The most skillful therapist, in the last analysis, will only be able to produce results in proportion to the stage of the cancer when he first sees it. He is earth-bound not so much by his therapeutic weapons, which have increased annually,[1] but by the time which is lost between the onset of the disease and the initiation of treatment. Table I indicates the average time loss found among the 438 patients who had been seen in the Gynecologic Tumor Conference by the end of 1951. In view of the fact that the survival rate is strictly proportionate to the stage of the disease when therapy is initiated, this table also provides an indication of the number of women killed by time loss.

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Submitted February 23, 1953.

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The successful reduction of the mortality rate in carcinoma of the cervix, therefore, is not to make "every physician's office a detection center" as much as to insure that every physician's office is a center for the EARLY detection of cancer. To achieve this, the following weapons, already available, must be used extensively.

TABLE I

League of Nations Stage—Cervical Carcinoma	Time Loss in Months	
	Patient Responsibility	Doctor Responsibility
I	5.2	1.02
II	6.4	1.05
III	6.8	3.04
IV	14.8	2.87

(1) THE APPOINTMENT CARD

It is almost impossible safely to dismiss a woman from one's practice. Rather than to be discharged, a woman should be given an appoint-

ment for her annual or her semi-annual check-up. The pregnant patient learns the habit of periodic check-up examinations even when she is feeling well; postpartum this habit must be encouraged and extended.

The dental profession has long since accustomed its patients to the practice of sending reminder cards when check-up examinations are due. There is nothing in the Code of Ethics of the American Medical Association which prohibits such a practice, yet the physician has fallen behind in using such a technique effectively. "There is no diagnostic procedure nor therapeutic weapon which will save the woman who stays at home." Furthermore, much of the responsibility for getting the woman into the physician's office rests with the doctor himself.

Such simple procedures as congratulating the asymptomatic patient who reports for examination; spending a few minutes with each woman on cancer education; and re-issuing an appointment card for the next examination—all of these are weapons too often ignored in the fight against pelvic malignancy.

(2) THE EXAMINING TABLE

It has become the mark of the quack and charlatan in our profession to claim remarkable diagnostic powers based on "radio-emanations," or on a magic machine. Those who claim to diagnose malignancy without in some direct way examining the patient are subject to our periodic prosecution and our constant scorn. It can quite correctly be interpreted from this that the non-quack will examine the patient; it can be quite properly concluded that those who do not examine the patient border on quackery in their practice.

In September of 1951 a 51 year old woman registered in the Tumor Conference of the Ohio State University Health Center giving a 10 month history of abnormal vaginal bleeding. Seven months prior to reporting to the clinic she had telephoned her physician and had described to him her symptoms of increased bleeding and intermenstrual flow. The physician had ascertained the address of the patient's nearest drug store and had telephoned there a prescription for ergotrate. The bleeding persisted, and the patient arrived with a total of 10 months of time lost, seven of them attributable to her "physician." Pelvic examination revealed a League of Nations Stage IV cervical carcinoma. Here is an instance in which failure to employ the appointment card and the examining table represents not merely poor cancer detection work, but actually criminal negligence.

(3) THE BIVALVE SPECULUM

More carcinomas start at the squamo-columnar junction on the cervix than at any other point of similar size in the human body. The fortunate fact that this all-important area can be easily visualized should be one of the greatest aids in early cancer detection. Such visualization does not require complex instruments with difficult optic systems; the vaginal speculum was first devised by the ancient Egyptians, and few subsequent instruments have equalled it in diagnostic usefulness. Omitting a speculum examination, like omitting recto-vaginal examination, is attempting to achieve a diagnosis on partial information.

(4) THE CERVICAL SMEAR

The cervical smear and Papanicolaou stain represent potential rather than present contributions to cancer detection. Certainly the smear is not diagnostic; the final diagnosis of carcinoma is achieved by histology, not cytology.

Those studies which have rejected the cervical smear as a screening device,[3] however, are still open to question. In most instances the argument against the routine mass use of the cytologic spread has been largely economic, and in these instances the slides were being read by pathologists. Were all red blood cell counts performed by graduate pathologists, the same arguments of time and money could be adduced to indicate that the determination of the number of circulating red cells was not a feasible laboratory study. That mass cytologic surveys (like the red or white cell counts) may become a duty of the trained technician is a possibility not to be dismissed too lightly.

For the present, however, the clinician and his patient are best protected by observing the following facts concerning the place of the cervical scraping:

(a) There are a considerable number of false readings—both false positives and false negatives. Should a negative reading lead to complacency, the patient will suffer rather than benefit from smears.

(b) The place of the cervical smear is in the **normal appearing** cervix. The **abnormal** cervix should be biopsied.

(c) A positive or "suspicious" smear should lead to biopsy, not therapy. The diagnosis of malignancy is a biopsy diagnosis.

(5) THE CERVICAL BIOPSY

The rule that "A cervix bad enough to cauterize is bad enough to biopsy" is subject to all the inevitable exceptions and exemptions that any absolute rule in clinical medicine must have. The postpartum cervix which by the eighth or tenth week postpartum (not sooner) still remains raw, eroded and everted represents, in most instances, such an exception. On the other hand, the rule does stress the broad (and self-evident) truth that it is well to establish a diagnosis before initiating therapy.

Biopsy is a simple office procedure, and the four quadrants of the cervical face can be con-

veniently sampled without discomfort to the patient. Had the cervical smear been developed first, and had our diagnostic efforts been limited to cytologic study of smears, then the sudden introduction of the tissue biopsy as a new procedure and the "latest thing" would be greeted with great medical enthusiasm, and with a far more extensive use of the biopsy than one sees today. We are perhaps too accustomed to the biopsy to realize its great worth as a weapon for cancer control.

(6) CERVICAL CARE

There is little doubt that the proper care of the cervix reduces the incidence of cervical carcinoma. Unfortunately it is impossible to state that cervical cauterization or conization will completely rule out the development of carcinoma; both in the 776 patients registered in the University Hospital Gynecologic Tumor Conference at the end of 1952, and in the more extensive series reported by Cashman[4] there are some patients who have developed cancer of the cervix after proper cauterization and good cervical care. Nevertheless, it remains true that the healthy cervix is less likely to develop carcinoma than is the unhealthy one, and, together with the speculum and biopsy forceps, the cautery tip and the conization loop are among the most valuable pieces of equipment available. It has been well demonstrated[5] that such cervical care significantly reduces the occurrence of carcinoma of the cervix.

SUMMARY

The frequency of cervical carcinoma can be reduced, and the early detection of cervical carcinoma improved, by the use of weapons which are readily available. The conscientious application of these weapons is the individual obligation of all physicians.

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Bronchoscopy

Bronchoscopy is always indicated in any case of chronic, persistent cough. It is a most valuable aid in the study of carcinoma of the lung. Although in the past decade great strides have been made in the field of thoracic surgery, particularly in the surgical treatment of carcinoma of the lung, if continued progress is to be made it is essential that operation should be performed early. Unfortunately, carcinoma of the lung is not limited to men past middle age; it can occur at any period of life, and in women as well as men.—Herman J. Moersch, M. D., Rochester, Minn.; J. Arkansas M. S., 49:139, February, 1953.

Ulcerative Colitis Treatment

We have found, universally, a greater than normal sensitiveness of the intestinal tract to carbon dioxide gas which, to ulcerative colitis patients, is a decided irritant, and recognition of this has formed the basis of our dietary regime. Naturally, any or all other proposed factors in these cases should be given their proper consideration and value, but our treatment, with the above in mind, has resulted more satisfactorily, when closely adhered to, than any others employed to date.

Recently cortisone, ACTH and antibiotics have been of great aid. However, we must bear in mind that the use of such antibiotics in some patients tends to allow an increased growth of the fermentative higher yeasts and molds which, in turn, produce carbon dioxide gas from the lower carbohydrate foods and which would not do so under the normal bacterial flora now suppressed. Elimination of the sources of carbon dioxide gas being our immediate goal, we might, in such cases, have to limit the antibiotics to intermittent short periods rather than a long continuous stretch.

Without obstruction, as is easily appreciated, carbon dioxide gas in the intestinal tract is derived only from carbohydrates; i. e., sugars and starches in various forms. The amount and type of available carbon dioxide producing fermentative material of any meal in passage through the intestinal tract, usually governs the amount of irritation at the time.

The generally prevailing form of dietary treatment for such cases, is a bland diet, low in roughage but containing such excellent carbon dioxide producers as cereals, milk and milk products, vegetable juices, fruit juices, soft drinks and malted beverages, pureed fruits and vegetables. Clinically we find the lactic acid fermentation and carbon dioxide production of these foods far more irritating to the intestinal tract than roughage. For example, the sugar content of juices is readily available for fermentation and carbon dioxide formation, whereas in fresh fruits the pulp must be slowly digested before the sugar is released. We limit roughage, to some extent, only in the acute stage. . . . Fats, even when rancid, do not produce the irritative carbon dioxide gas and . . ., proteins or nitrogenous elements of diet, of themselves, also do not produce carbon dioxide gas.

The dietary treatment thus resolves itself into keeping within the individual's tolerance for carbon dioxide producing foods and then gradually raising the tolerance, in due time, after healing the ulcerative lesions in the intestinal tract.—M. B. Levin, M. D., and B. A. Gwynn, B. S., Baltimore, Md.,*Am. J. Digest. Dis.*, 20:29-31, February, 1953.

Treatment of Sterility—Practical Considerations

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The Author

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SINCE the time of Malthus, human infertility and correlatedly the birth-death rate ratio has been of interest to the Church, the State, the Military and to Medical Science. The problem of infertility is extremely important, approximately one out of five marriages being involuntarily childless. It is our purpose here to give a resumé of the sterility problem with suggestions for treatment. Medical Science in its investigation accomplished little if anything of constructive value prior to 1920. The fundamentals had been laid by the work of Loeb, Fraenkel, et al. (i. e. demonstration of the sensitization of the endometrium to trauma or foreign body by the corpus luteum and the latter's quality of being essential to the maintenance of the fertilized ovum in the first six weeks of its existence) and the later hormone researches of Allen, Doisy, Frank, Corner, Hartman, et al.

MANY FACTORS INVOLVED

The position at present is that there is not a paucity of circumstances having an influence on infertility problems, but an almost embarrassing multiplicity of them. A large number of variable and nearly imponderable factors lie within the realm of possible involvement in any given case of infertility. Obviously it is apparent that all possible factors cannot be essayed systematically in succession. This procedure would be economically impossible to an average patient and extremely time consuming additionally.

The psychological line to pursue with the patient, who is interested in results only, is obviously that of direct action, at the expense of scientific exactitude in the determining of the relative effectiveness of the corrective method employed. Since a number of apparently minor factors may contribute to the total of infertility, it is necessary simultaneously often to "shell the woods" for therapeutic success. Hence accurate knowledge of the absolute percentage value of therapeutic procedures accumulates extremely slowly because perforce a dozen or more possible remedial measures are being taken simultaneously.

It is our purpose here to assay as nearly as possible, in the light of clinical experience and the present state of our knowledge, the relative value of the therapeutic weapons at hand and emphasize a relatively small number of fundamental procedures which should be done first, and in approximately this order, any one of which may immediately solve the problem and produce the successful result of pregnancy.

Submitted November 15, 1952.

BASIC TERMS DEFINED

Any consideration of infertility or sterility predicates a definition of basic terms, viz. (1) Absolute sterility. (2) Relative infertility. Absolute sterility is, of course, complete inability to conceive, such as subsequent to hysterectomy, menopause, oophorectomy or salpingectomy, often x-ray or radium exposure. All other situations, granted a potent sire, are variably amenable to treatment with a widely varying height of infertility threshold.

NORMAL BARRIERS

A primary consideration in the evaluation of infertility is an appreciation of the normal or physiologically high threshold barrier to fecundation in the human. In brief, the average nullipara is a difficult mammal to impregnate. This factor probably does much to hold the coefficient of illegitimacy within reasonable bounds. The late great Gideon Wells characteristically defined man as "a heterozygotic, polyhybrid bastard of low fecundity" and in actual practice, it seems that for the one instance of the woman who never menstruates after marriage and delivers the fetus under nine calendar months, for those cases are always noted, human nature being what it is, there are many women who after relaxing various contraceptive precautions, require, it has been estimated, as many as 200 coitus before impregnation occurs. The "hopelessly fertile" woman who becomes pregnant following a single sexual exposure is outnumbered greatly by her much more numerous infertile sisters.

Additionally, many women are met with in practice who, marrying in their early twenties, practice rigid contraception for three to five years only to find when omitting contraception that pregnancy does not occur without therapy. A large contributing factor, however, is the emergence of the woman into a higher age group. A near approach to the age of 30 does not place her in the optimum age group for fertility.

A discussion of the pathology as well as the

abnormal physiology underlying infertility is to all intents and purposes a study of its etiology. A circumstance frequently met with in infertility is the almost immediate ejection (effluvium seminis) of the ejaculation of semen by exaggerated clonic contractions of the constrictor cunni and other paravaginal and pelvic floor musculature. This is usually associated with anatomical diminution or absence of the receptabulum seminis, i. e., the shallow cul-de-sac underlying the cervix which in the presence of a positive Huhner's test, contributes so much to the successful survival and upper progress of the spermatozoon by concentrating it about the external cervical os. A successful Huhner test gives a favorable outlook in so far as the vaginal environment is concerned for the survival of the spermatozoa. Sodium bicarbonate douches approximately every other day are possibly advisable as a routine measure with the addition of glucose. The advisability of this practice is questioned by other authorities (Greenhill).

HYPERACIDITY OF VAGINA

Hyperacidity of the vagina due to increased concentration of Döderlein bacillus and other acidophile vaginal organisms resulting in a negative Huhner test is a real but nebulous unfavorable factor because accurate determination of the vaginal *p*H seems impossible owing to the uneven distribution of organisms and must be dealt with empirically. Various types of pathology of the cervix play an important role. Polycystic ovaries of unknown etiology are often associated with infertility or almost absolute sterility. Chronic oophoritis, a vague entity appearing as a thickened ovarian cortex associated with cystic degeneration has been treated by partial decortication of the ovaries (Reycraft). The results of this procedure have not yet been evaluated.

Endometriosis, almost invariably associated with at least relative infertility and open fallopian tubes, may be dealt with successfully frequently by conservative oblative surgery, i. e. preservation of grossly normal ovarian tissue following resection of chocolate cysts.

Tubal disease especially in the pre-sulfa and pre-penicillin era was the cause of sterility par excellence and "one-child" sterility was considered almost pathognomonic of tubal Neisserian disease.

The outstanding success of these drugs in aborting tubal and epididymal disease has relegated the gonococcus to a much more inferior position as an etiological factor in producing sterility.

INFERTILITY

Infertility often has a characteristic anatomical habitus which is indeed very similar to that of dysmenorrhea. The infantile uterus, often in retrocessed position with acute anteflexion and a pointed tight cervix becomes impregnated with marked reluctance. For purely mechanical and anatomical reasons, dysmenorrhea and scanty periods are frequently associated with infertility. Similarly a "dwarf" or normally shaped but abnormally small uterus with normal or slightly enlarged, i. e. well palpable ovaries and regular normal menses is a problematical risk for the *initial* pregnancy.

However, once such a uterus is impregnated, resulting in miscarriage or in full term pregnancy, heightened future fertility is the rule. Unaccountable cases with normal pelvic findings sometimes are notably resistant to impregnation but these usually are successful, given time or following the employment of the most empirical alternative measures such as increasing the anterior cant of the uterus with the Smith-Hodge pessary. These rather rare resistant cases suggest a possible allergic factor or an anaphylaxis to spermatozoa or testicular secretion. The limited experimental work on physiological contraception from the standpoint of immunization is equivocal and blood grouping is apparently uninvolved in reproduction aside from the Rhesus factor.

MALE STERILITY

A most important advance in the understanding of infertility was the universal recognition of the considerable responsibility of the male as an etiological factor. The male should be investigated without fail before the female is subjected to any of the unpleasant or involved procedures often necessitating anesthesia.

Any consideration of reproduction in the human cannot, therefore, neglect the question of male sterility or infertility, as male responsibility for infertility is estimated upon reasonable statistical grounds to be as high as 35 to 40 per cent. The human male should have a spermatozoa count of 70 to 80 million per cubic centimeter and have approximately normal libido and potentia to qualify as "good sire." A successful impregnation has been obtained, however, in our hands with a spermatozoa count as low as 8,500,000. This result presumably was expedited by means of artificial insemination.

Spermatozoa should be, ideally, morphologically uniform with a minimum of deformed or bizarre heads and with normal motility. Cooperation of an expert urologist should be employed in any marked deviation from the normal in number motility or morphology. Early fetal death following fertilization by deformed spermatozoa with corresponding early abortion may well be nature's method of screening potential monsters. Unfortunately it is impossible to examine by inspection the ovarian cortex of a woman for defective ova and so correspondingly, the monthly

contribution of the female to impregnation must be taken on trust.

TREATMENT

Many diagnostic procedures are innately therapeutic and among these is the Rubin test. Evolved early in sterility research by Isadore Rubin, it was and has remained the most important step in its investigation. Elaboration of the original method of carbon dioxide injection using injectable opaque media (lipiodol®) has never escaped the original prejudice of the writer generated by several pelvic abscesses developing immediately after the procedure in our clinic. It is our feeling, however, that if latent cervical or tubal infection can be ruled out clinically, its use is justified in obscure or equivocal behavior with the original Rubin technique.

We also feel justified in reasserting that there is a definite hazard implicit in the procedure and it should not be employed with the nonchalance of many routine diagnostic procedures. It is worth while to mention the fairly frequent occurrence of intermittent cornual spasm as a factor in sterility. Every experienced gynecologist is familiar with the circumstance of an apparently definitely negative Rubin test at ordinary pressures followed by completely normal ones at later periods.

Male potency having been established, expert pelvic examination should reveal whether the gross pelvic examination is within the limits of normal. Cervical disease (erosion, infection, marked stenosis or deformity) tenacious mucus plug should be remedied, usually yielding to cautery, topical applications for dilatation. Marked displacement should be corrected by pessary or surgery. The modified Gilliam procedure (Cullen) is probably the procedure best calculated to weather the storms of succeeding pregnancies. In our own experience, retroversion has never recurred with this technique even following repeated pregnancies. Salpingostomy performed by meticulous technique has been reasonably successful employing the Cuff procedure with unilateral slit (Graves). Meigs, however, finds it rarely succeeds in routine practice and as is well known tubal reparative surgery is extremely delicate and should be attempted only by the most expert.

This procedure, however, has found success in fairly numerous cases, i. e. detachment of fimbria from the pelvic floor, omentum and intestines, etc. The amount of trauma necessary to effect detachment is, of course, inversely proportional to the number of future tubal patencies obtained in these cases. Distal tubal insufflation of the fimbriated end of the tubes should always be employed in any transperitoneal investigation because cornual occlusion has ordinarily been deemed irreparable surgically. The employment of the Bonney clamp and Sovak syringe is a great help in the procedure.

Reimplantation into the uterus of a distal patent fragment followed by pregnancy, however, has been accomplished in the hands of Cullen and has recently been recommended as being eminently practicable by Meigs. In general, however, successful tubal surgery following serious trauma due to infection lies in the category of surgical miracles. The direct cornual implantation of the ovary on its own pedicle into the uterine cornu is also in the forlorn hope class (Estes operation) and has been successful in isolated cases in various hands.

DILATATION AND CURETTAGE

The most frequently indicated surgical procedure is a properly performed dilatation and curettage and the insertion of an inlying uterine stem pessary of the Carstens type for approximately six weeks. This procedure is subject unjustly to an almost universal surgical opprobrium by the uniformed due to confusion with the always ill-advised employment, often in unscrupulous hands, of the inlying "collar button" type of pessary, as a contraceptive measure or even as a method of producing very early abortion and which brought almost inevitable sepsis in its wake. Proper employment of the silver stem pessary is of great value in the treatment of the infertile or hypoplastic uterus. (Weir, Graves, Curtis, et al.)

It had been shown by Loeb in 1909 that the uterus in mammals, sensitized by corpus luteum would react to a silk suture passed through it exactly as it would to another foreign body, namely a fertilized ovum, by the formation of placentoma, i. e. an all-out decidual reaction. Macomber reported a case supporting this also (pseudo-pregnancy). In our hands a single stroke of a curette produced a striation flanked by lumpy masses of decidua-like cells in a uterus previously sensitized by corpus luteum.

In other words, the uterus interprets any or every trauma or intruder as a pregnancy and therein lies the rationale of the heavy silver pessary employed in the grossly hypoplastic uterus with a stenotic cervix often distorted by an exaggerated anteflexion. In brief, the procedure is designed to leave the uterus and cervix in a condition approximating the anatomical situation following an abortion at three months or even a normal full term parturition with perfect involution. The ovarian mechanism also may have been influenced by the pseudo-pregnancy reaction presumably and the indisputable vulnerability of the postparturiant women to pregnancy automatically comes into being. Foreign body reaction of the silver pessary apparently produces contractions and a local reaction sufficient to produce increased vascularity and

a grade of permanent hypertrophy in an underdeveloped uterus.

OVULATION TIME

The exact determination of ovulation time has long been the philosopher's stone of the infertility problem. Prior to 1930 little of cogent value was even assumed concerning it. No less an astute clinician than William Graves in his early editions of his authoritative gynecology, quoted from German literature giving tentative figures on the relative incidence of pregnancies in the various weeks of the menstrual cycle as 48:32:14:1 showing recognition of the infertile period immediately premenstrual but no knowledge of the fact that the most vulnerable period for impregnation is definitely mid-month.

Wilfred Shaw in London as early as 1927 made the observation (personal correspondence) that the corpus luteum appeared as a grossly recognizable structure at laparotomy in a woman with a normal menstrual cycle between the 11th and 14th days as a rule, postulating ovulation pretty definitely between the 10th and 14th days. This and subsequent work of Brewer, Rubinstein, Rock, Hertig, Allen, Hartman, Corner, Greulich, Black, Papanicolaou, et al., located the ovulation date ordinarily between the 12th and 14th days.

From a standpoint of speed, practicality and expediency, reliance can and should be placed in the temperature criterion, (Rubinstein, Zuck). Experience in compiling temperature curves in women with varying grades of infertility shows an over-all resemblance which in the light of existing experimental evidence points unmistakably to ovulation occurring at the point of the basic temperature reading. This on repeated checking seldom varies to any considerable extent. A typical abrupt drop in temperature usually to the lowest point of the monthly range is very uniform being followed by a variable but definite post-ovulational temperature plateau.

Perusal of some hundreds of these records establishes the requisite critique for the interpretation of all except the rare extremely atypical records. In the normal 28 day cycle the 13th or 14th day is the rule for the ovulation date with variation for longer or shorter cycles. Recognition of this fact has proved a therapeutic bonanza. It enables the optimum time for impregnation to be bracketed with coitus, best conditioned for the survival of the spermatozoon by mild alkaline douches taken every other day, several previous days of sexual abstinence, avoidance of excessive exercise and adequate diet for the marital partners.

DRUG THERAPY

The only drug therapy of sound rationale is the administration of anterior pituitary substance (synapoidin® or antuitrin®) from 48 hours before, up to the expected time of ovulation. Ideally this should implement and promote the mechanism of follicle ripening. This gonadotropic property of augmenting follicle ripening is clearly demonstrable experimentally and although the exact efficiency and the gonadotropic mechanism in the human is unknown, an effort should be made to employ it empirically.

Thyroid extract seems a desirable adjuvant in sterility. It seems to have an almost catalytic action with the ovary, apparently being a definite aid in dysmenorrhea, menopause disturbance, habitual abortion, etc.

It seems quite possible that relative or actual cornual spasm exists and for that reason a single refractory Rubins test should not be regarded as conclusive proof of tubal impermeability. In our hands negative Rubin tests have been followed by normal findings a considerable number of times, in an interval of not exceeding several months. This situation being succeeded by a normal pregnancy strongly suggests spasm of a relatively transient nature as a clinical entity of functional variety.

ARTIFICIAL INSEMINATION

Amidst the mass of factual detail relating to the infertility problem, the bulk of which must be dealt with briefly in an article of such limited scope, the procedure of artificial insemination stands forth importantly. This procedure which appeals to the lay imagination with almost unbelievable force under the pseudonym of "test-tube baby" is, as might well be expected, grossly misunderstood. When the true nature of the method is explained to potential parents, employing the spermatozoa of the husband particularly, and the demonstration that it simply gives spermatozoa a three-inch handicap in a long and hazardous journey of approximately six inches, it may serve to quiet objections arising in religious or other taboos expressed as being "contrary to nature."

Artificial insemination, however, is at best a procedure which must be regarded as an empirical method of therapy, because inevitably artificial insemination is associated with normal coitus which confuses the correct identification of the mechanism actually responsible for any given pregnancy. In a properly performed artificial insemination, it is advisable to employ a special instrument, i. e. a syringe with long semi-flexible nozzle to spray both the uterotubal ostia with a suspension of spermatozoa tested for motility.

The reason for this is, of course, that it is impossible to tell, in any given month, in which tube the ovum may be. This method should never be urged as a panacea for infertility as it is by no means infallible from a statistical standpoint. Certain cases of relative infertility are accompanied by an increased percentage of defective, deformed or bizarre-shaped spermatozoa. This is especially well known in animal

husbandry, i. e. (bulls) hence the apparent reluctance to easy impregnation could possibly be construed as nature's objurgation against its occurrence.

Included in the course in the general survey of the patient should be a basal metabolic rate reading and moderate administration of thyroid extract. Last moment checking of the motility of spermatozoa before injection should be done and the sperm if collected in a condom should be immediately removed from it as the chemicals used in rubber curing are spermatotoxic.

Several considerations are worthy of mention, namely the reflex or spontaneous ovulation stimulated by an action of coitus notably habitual in rabbits, guinea pigs, etc. This may rarely but possibly occur in certain women. This would account for the time discrepancy of the known pregnancies occurring outside of the normal ovulational period. The sterile sound should be passed after each menstrual period during the period of therapy. This simple therapeutic maneuver was followed by a notable percentage of pregnancy in the early days of sterility therapy when it was employed alone.

From this group of factors definitely bearing upon impregnation, the prime essentials seem to be the following which should be investigated and employed, roughly in this order, keeping in mind that each therapeutic measure may be the essential one in producing impregnation.

SUMMARY

Following adequate and thorough investigation of the male, the following procedures are of primary importance and it is advisable that their performance, in approximately this sequence, be carried out.

1. A thorough indoctrination of the patient and husband should be carried out and a forewarning of the circumstance that the treatment may be prolonged and fraught with disappointment for a variable period of time should be made clear.

2. Restoration as completely as possible of relatively normal pelvic anatomy. Cervical infection should be carefully and thoroughly treated. In marked hypoplasia, distortion (marked flexions) or stenotic cervices, dilatation and curettage with temporary use of the heavy Carstens pessary should be performed in nullipara.

3. The Rubin test and Huhner test (less important) should be performed. Alkaline douches instituted. Tubal insufflation is, in many cases, an easily performed office procedure but is more reliable performed under anesthesia prior to the dilatation and curettage which is often indicated.

4. Determination of the presumable ovulation time by the temperature method repeated if necessary by successive monthly tabulation. Bracketing of presumable ovulation period by timed coitus. Limitation of the number of preovulation coitus to avoid decimation of the spermatozoa count, elimination of the excessive fatigue and regulation of diet, administration in the preovulation period of three to four days of gonadotropic hormone (synopoidin,® antuitrin,® etc.). Administration of thyroid extract in dosage guided by basal metabolic rate. Attempt control of vaginal *p*H by sodium bicarbonate douches on alternate days.

5. Artificial insemination with aseptic precautions, the injected sperm diluted 50 per cent in physiological saline and deposited into the depth of the fundus. An attempt should be made to spray both tubal orifices as it cannot be forecast in which tube the ovum will be contained. This is accomplished by rotating the slightly curved flexible nozzle of the syringe through 180°. Condom specimens of spermatozoa should be placed in sterile glass containers immediately after orgasm as chemicals used in rubber curing are spermatotoxic. Motility of sperm should be checked immediately before injection.

Apparently successful artificial insemination must be assumed only as the responsible agency because invariably normal coitus is being practiced coincidentally. In more complex anatomical situations with damaged or adherent tubes or ovaries, tubal or ovarian homotransplantation may be considered or salpingostomy, bearing in mind that these procedures are unsuccessful in a high percentage of cases. Any ameliorative or reparative surgery should be attempted only by those of particular experience.

The foregoing schedule of procedure, while not exhaustive, is probably comprehensive enough to form a systematic pattern of attack which may best be calculated to lead to success in any given case of sterility.

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Diet Treatment of Atherosclerosis

Atherosclerosis appears most commonly and severely in those people who take diets rich in fat and cholesterol, and who in addition are well fed. The disease appears in many people who have not consumed fat diets. Therefore, diets low in fat and cholesterol do not guarantee freedom from atherosclerosis.—Edward L. Bortz, M. D., Philadelphia; *J. Lancet,* 73:93, March, 1953.

Use of ACTH in a Case of Friedlander's Pneumonia

HAROLD E. MAY, M. D.

FRIEDLANDER'S pneumonia remains a dread disease in spite of the "broad-spectrum" antibiotics. In a recent report by Kirby and Coleman[1] six out of 11 patients died with Friedlander's pneumonia. Klebsiella pneumonia accounts for approximately 0.5 per cent of all cases of pneumonia and is four times more frequent in the male than in the female.

Roentgen findings of a dense consolidation with a sharp edge or convex advancing border as stressed by Felson and co-workers[2] should prompt further investigation. Very little information is available concerning the effectiveness of aureomycin, terramycin, chloromycetin,® streptomycin and their combinations in this disease.

IMPORTANCE OF BACTERIOLOGICAL DIAGNOSIS

The importance of early diagnosis by sputum smear and culture cannot be over-emphasized. An unfortunate clinical approach has evolved in recent years with respect to the bacteriological diagnosis of acute infections. This approach has almost reached the point that acute febrile illnesses fall into two classes—those which respond promptly to penicillin and those which do not. The delay thus occasioned in definitive diagnosis in the latter class often proves costly and the typical clinical and bacteriological picture may be masked by the early penicillin administration.

Before the days of chemotherapy prompt bacteriological diagnosis of acute pneumonia was routine. When type-specific antipneumococcus sera became available such diagnostic procedures were greatly refined. Nowadays, in contrast, obvious early lobar pneumonia is lightly regarded. Hospitalization is seldom necessary. Yet a refractory case may not be recognized until the disease has progressed to an advanced stage before identification of the offending organism is established. Such may be the case in a Friedlander's pneumonia, whose fulminating course is notorious and the attendant mortality high. The case herewith presented illustrates this point.

CASE REPORT

History: This 34 year old white male was well until the afternoon of October 16, 1952, when he suddenly became ill while playing golf and experienced a shaking chill followed by nausea and vomiting. He was seen in a doctor's office and given 300,000 units of procaine penicillin. The following day, he ached all over, had chills and fever, pleuritic pain in right anterior chest and a tight nonproductive cough. His past history was negative except for pneumonia three times in childhood. There was no history of alcoholism.

Physical Examination: On admission to the hospital* on October 17, the blood pressure was 106/64, temperature 102° (rectal), pulse 105, respirations 40. He was an asthenic white male who appeared critically ill. His eyes rolled upward with only the sclera showing except for brief intervals of forced concentration. Chest examination revealed splinting of the right chest and dullness over the right lower lung field. Auscultation revealed bronchial breathing and fine crepitant rales. The clinical impression was that the patient had a right lobar pneumonia.

Hospital Course: The patient was placed in an oxygen tent, given crystalline penicillin, 50,000 units every three hours, and intravenous fluids. The second hospital day: A portable chest x-ray revealed a dense consolidation of the right upper lobe and patchy pneumonia in the right middle lobe; some downward bulging of the minor fissure was noted.

The patient remained unimproved and appeared very toxic. His red blood count was 4,840,000 with hemoglobin 14.5 grams; white blood cells 7,850; differential: myelocytes 1, juveniles 6, stab forms 72, segmented cells 4, lymphocytes 16, monocytes 1. The patient was given massive doses of penicillin together with dihydrostreptomycin 0.5 gm. every 12 hours, aureomycin 250 mgms. every 4 hours, and whole fresh blood. His cough was still nonproductive and no sputum studies were obtained.

The third hospital day his condition was very critical. The rectal temperature was 103.8°F. and pulse rate 155. Consolidation of right upper and mid lung field was still present. The white blood count had dropped to 3,250 with a severe left shift as follows: myelocytes 2, juveniles 7, stab forms 68, segmented cells 4, lymphocytes 14, monocytes 5.

He was profoundly toxic with a mounting, thready pulse. The collapse of the resistant forces of the body was evident by the toxic depression of the bone marrow with alarming leukopenia. The lack of response to penicillin and the general clinical picture was thought to suggest Friedlanders' pneumonia. Blood culture: a scanty sputum specimen and throat smears were taken for culture and sensitivity tests were ordered to determine the degree of resistance of cultured organisms to the various antibiotics.

Treatment: It was evident that further delay in more specific therapy was frought with danger. The non-specific value of ACTH in combatting toxemia and shock was thought sufficient indication for use of this drug. Accordingly the patient was given ACTH 40 mgms. every six hours

The Author

● **Dr. May, formerly Barberton, Ohio, has been recalled to active duty with the U. S. Army and is now stationed in the European zone.**

*Medical Service of Peoples Hospital, Akron, Ohio.
Submitted January 19, 1953.

in the form of Acthar-Gel.® By the following morning the patient showed dramatic improvement. The rectal temperature had dropped to 100.2°F. and the pulse rate to 88. The white blood count had risen to 6,150. He was alert and asking for food.

Laboratory Findings: Subsequent laboratory reports showed the presence of Friedlander's bacilli in the smears and cultures. Sensitivity tests revealed the organism to be resistant to penicillin and aureomycin, moderately sensitive to terramycin and somewhat less sensitive to streptomycin and chloromycetin.®

Accordingly he was given 500 mgms. of terramycin intravenously every six hours. This was supplemented by oral chloromycetin® which was discontinued after two days because of nausea. The ACTH was discontinued after four days since the patient was greatly improved, afebrile, had a bradycardia of 56 and the white blood count had risen to 13,000. On the eleventh hospital day considerable resolution of the pneumonic process was apparent.

On November 8, 1952, twenty-three days after the onset of the illness the patient was discharged from the hospital. Oral terramycin was continued for one more week.

Follow-Up: On December 5, x-rays studies of the chest showed almost complete resolution of the pneumonic process. At this time, he had regained 20 pounds of his lost weight and returned to work.

SUMMARY AND CONCLUSIONS

1. A case of Friedlander's pneumonia is presented with recovery. The profound toxemia was thought to be controlled by the administration of ACTH. It appeared that this therapy was life-saving until more definitive treatment could become effective.

2. A plea is made for prompt routine bacteriological diagnosis of acute pneumonia. Cultures from throat smears and sputum should be planted before specific therapy is instituted. Since the advent of penicillin this procedure has fallen into disuse in most hospitals. Only by such means can the diagnosis of acute pneumonia be recorded statistically and the rare case of Friedlander's pneumonia can be recognized early.

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Clinical Symptoms Sometimes Lacking

Many physicians are reluctant to believe that people can have pulmonary tuberculosis when they show no clinical symptoms and there is nothing to direct attention to their lungs except a shadow on a chest film.

The tendency is to reassure the patient that the lesions are old and inactive, but the tragedy comes later when the same patient is found to have moderately or far advanced disease.—Alan L. Hart, M. D., *Public Health Reports*, December, 1952.

KEEPING UP WITH MEDICINE

• IN THESE days of muddled thinking about social problems, alcoholism is confused with heavy social drinking. Alcoholism is a problem in the health of the public but it is not a public health problem; or at least is only so far as the use of alcohol by an individual (a victim of alcoholism or not) plays a part in accidents in which innocent persons are injured.

* * *

• OVEREATING is apparently the most devastating nutritional disorder in the United States today. This does not mean that we can get along on less food but rather that we should be going to a high protein, low fat and carbohydrate diet. This is one that will tax our agricultural resources the most.

* * *

• A NUMBER of cases of vitamin A poisoning are appearing in the literature. Symptoms begin to appear after several months of substantial overdosing with this vitamin.

* * *

• RECENT research has shown that human milk contains a complex nitrogen compound which gives breast-fed babies a higher degree of resistance to certain virus diseases including poliomyelitis.

* * *

• IT IS PROCLAIMED that the most needed health services for school children are (1) protection from tooth decay which means restriction of carbohydrates, avoidance of sweet beverages which contain phosphoric acid, above all dental exercise, and in selected cases, the painting of flourine compounds on the teeth; (2) accidents whose prevention is a cooperative effort of parents and teachers; (3) malnutrition, which is a responsibility of the parents; (4) unhygienic environments—again a responsibility of parents; (5) insufficient convalescence after illness which is in part our responsibility; and finally, infectious diseases, the spread of which is a function of the public and school health authorities with the cooperation of the family physician. To assign all of the factors to the school health program is not being realistic but rather taking the easiest way to what appears to be a desired goal. Public health and health of the public are two different things.

* * *

• DISEASE, fatigue, underweight, heart defects, asthma, hearing disorders and self-consciousness are all associated with poor posture.

* * *

• TWENTY-FIVE GRAMS or more of protein are needed to maintain the blood sugar at an effective level for 3½ hours. This should be taken into consideration in planning breakfasts.—J. F.

Embolectomy Combined With Retrograde Milking

BERT SELIGMAN, M. D.

THE functional result following successful embolectomy in some cases leaves much to be desired. A cold foot, intermittent claudication, edema, atrophy, paresthesia, nocturnal cramps of the foot, calf, or thigh, may singly or together manifest themselves post surgery. In these cases the fact that the limb is spared is partial compensation to the patient for the alterations in physiology. In the instances where gangrene supervenes, despite the removal of the embolus, thereby necessitating amputation, the surgeon as well as the patient find scant consolation in the published percentages indicating the frequency with which this end result occurs.[1]

Mechanical obstruction, associated vasospasm, consecutive thrombosis and contiguous vein involvement[2] all participate in assessing the end result of acute arterial occlusion due to embolus. The time interval elapsing between the occlusion and the removal of the obstructing agent, the relationship between the diameter of the secondary thrombus and the lumen of the artery, as well as the extent of involvement of the collateral circulation are imponderables meriting consideration.

Each embolectomy invites careful individual consideration, certain basic operative fundamentals being observed, with ingenuity as well as trial and error playing their respective parts. A recent addition to the operative routine of embolectomy has been retrograde milking as advocated by Keeley and Rooney.[3] They used a tightly applied Esmarch bandage from the toes to the mid thigh to milk previously inaccessible clot to an area of accessibility. Utilizing this technique a popliteal embolus was successfully removed.

CASE REPORT

History: Mr. ....., 60 years old, had a cataract removed from his left eye on December 13, 1951. His convalescence was uneventful until 4:15 p. m. on December 16th when he experienced the onset of numbness in his right foot, diminished sensation in the lower half of the leg, pallor of the foot, no dorsalis pedis pulse on the right, which was present on the left.

When seen at 10 p. m. the numbness was still present. The patient was fibrillating, and had a pulse rate of 70, with blood pressure of 110/70. The right dorsalis pedis, posterior tibial and popliteal pulsations were absent. The pulses in the left lower extremity were all present as was a weak pulsation in the right groin. The right foot and leg to mid thigh was cold, mottled in appearance, appeared shrunken and the veins were collapsed.

A diagnosis of embolus at the bifurcation of the common femoral artery was made and the patient taken to surgery.

Operation: Utilizing 1 per cent novocain® as a local anesthetic, a longitudinal incision was made in the upper third of right thigh down to the adductor canal. This was opened, and the common femoral, superficial femoral and profunda femoris arteries were isolated and bulldog clamps placed to control bleeding.

The common femoral was normal in size, soft, free of clot and had a good pulse, as did the profunda femoris. The superficial femoral was in spasm, which was not complete, was soft, free of clot and had a markedly diminished pulse. It was assumed that the embolus had traveled distal from its original point of lodgment.

A longitudinal incision was made in the superficial femoral artery just below the bifurcation, and a well lubricated polythene catheter introduced distally. It advanced to the upper margin of the popliteal fosa, by actual measurement, and all attempts with suction applied failed to extract the clot.

This was on Sunday, and all the time while I was manipulating the catheter and intermittently applying suction without success, through my mind was running the article by Keeley and Rooney read just the night before. An Esmarch bandage was sent for, but none was obtainable, so it was decided to use a 4 inch Ace® bandage reinforced with rubber. It was very tightly applied from the foot to the mid thigh, following which insertion of the catheter and application of suction produced the embolus with a 10 centimeter tail and numerous tiny tails probably produced in the collaterals.

The arteriotomy wound was closed with interrupted mattress sutures, and the thigh wound closed in layers. Inspection of the limb revealed the same cold, mottled, pulseless, shrunken extremity with collapsed veins. It was felt that the obstruction had been completely removed, but since anticoagulant therapy was to be instituted immediately, and not wanting to chance a retroperitoneal hematoma from a lumbar novocain® sympathetic block, a right lumbar sympathectomy was performed under nitrous oxide-oxygen-curare anesthesia.

Postoperation: Upon return to his room, the patient's feet were examined and the extremity had assumed a better color, as compared with the left leg and was warm down to the ankle. By the next day both feet were equal in color and temperature, but no pulses were palpable. The patient left the hospital in one week, and when seen January 7, 1952, had no pulses bilaterally, with a skin temperature of 29°C on the right and 21°C on the left. On January 22nd faint posterior tibial pulses were present bilaterally,

Submitted January 9, 1953.

The Author

● Dr. Seligman, Toledo, Ohio, is surgeon, vascular service, at Flower Hospital and at Maumee Valley Hospital.

with skin temperature of 29°C right and 21°C left.

Follow-up: He was last seen on January 3, 1953, at which time he had good bilateral posterior tibial pulses, and the skin temperatures were bilaterally 27.5°C. He returned to work on March 17, 1952, and has worked continuously at his regular job. Functionally, the leg performs very satisfactorily.

SUMMARY

A successful case of popliteal embolus removed through an incision in the superficial femoral artery, aided by retrograde milking with an Ace® bandage is presented. Twelve months postoperatively the patient is back at his regular job, and carrying on very satisfactorily.

Acknowledgment: I wish to thank Drs. D. C. Frick, E. F. Ward, Jr., and C. W. McNamara for kindly referring this case to me.

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Allergy in Relation To Deafness

The tissues most susceptible to allergic disease are three: the *skin*, the *gastrointestinal mucosa* and the *respiratory mucosa*. These are the tissues through which pathogenic microorganisms must pass to invade the body. Accordingly these tissues possess to the highest degree the ability to elaborate specific antibodies against foreign invaders.

In certain persons with an inherited predisposition these tissues also elaborate antibodies against ordinarily harmless foods or inhalants. When such a person inhales or eats the substance to which antibodies have been produced a reaction occurs in his tissues due to union of antigen and antibody, with tissue damage, liberation of histamine, edema, eosinophilia, smooth muscle spasm and increased flow of mucous from mucous glands. This is known as the allergic reaction, and hay fever is the classical example in the respiratory mucosa.

In recent years we have learned that the majority of chronic nasal and sinus disease is not primarily an infection, but is basically allergic, with superimposed secondary infection in the more severe cases due to the chronic edema and stasis. It is not so well known that chronic allergy of the middle and inner ear causes a considerable number of cases of deafness.—George E. Shambaugh, Jr., M. D., Chicago; *Illinois Med. J.*, 103:165.

Neurosyphilis

The Dattner-Thomas concept states that the results of cerebrospinal-fluid tests accurately reflect the activity of a syphilitic process in the central nervous system. This concept of cerebrospinal-fluid findings in cases of neurosyphilis has been summarized as follows by Thomas:

"1. Signs and symptoms of neurosyphilis are not reliable criteria of the activity of a syphilitic process in the central nervous system, because they may persist or become more marked as a result of past activity, or there may be transitory clinical improvement without a complete arrest of the syphilitic process as shown by spinal fluid findings. Also, the syphilitic infection may be very active within the central nervous system and still be asymptomatic.

"2. A positive spinal-fluid Wassermann test alone is not proof of active neurosyphilis. It merely indicates the specific nature of the infection, which may be already inhibited or completely checked at the time when the spinal fluid is examined. Activity is demonstrated only by the entire spectrum of spinal-fluid tests, among which increased cell counts and total protein determinations are of chief importance. Colloidal reactions are important but less informative than cell counts and protein determinations.

"3. In treated cases, spinal-fluid Wassermann tests and colloidal reactions may continue positive for more than five years after treatment has successfully arrested the syphilitic process. In an arrested case, cell counts should become normal within three to four months after treatment, and quantitative complement-fixation tests, protein values, and colloidal reactions should show a gradual but steady trend toward normal.

"4. Following malaria therapy or penicillin therapy of active neurosyphilis, the spinal-fluid findings may show a trend toward normal values, only to relapse later. Relapses however, rarely occur more than one year after therapy, and at Bellevue Hospital we have never observed a relapse of neurosyphilis more than fifteen months after treatment.

"If the cell count is not normal and there is no definite improvement in the other spinal-fluid findings six months after treatment, further treatment is imperative, regardless of the clinical status of the patient."

Few rules for the treatment of syphillis are without exception, and we have seen but few exceptions to those which have been mentioned. We, therefore, feel, as do most investigators, that the concept of Thomas is valid. Since we have seen cell counts which were abnormal six months or more following treatment become normal without further treatment, we do not feel necessarily that further treatment is imperative.—Robert R. Kierland, M. D., Rochester; *Minnesota Medicine*, 36:240, March, 1953.

Angiomas: A Dermatologist's Views

SAMUEL ROBERTSON MERCER, M. D.

VERY frequently a dermatologist is questioned by a fellow physician or consulted by the parents of a recently born baby as to the best procedure to be followed in the handling of a "blood tumor" or a birthmark.

TYPE

In most instances the lesion in mind is the common angioma of the so-called "raspberry" or "strawberry" type. In considering a large number of cases this particular form is the one most often seen. Although it may vary in number, color, size, shape and distribution, it is usually found on the upper half of the body. Frequently the marks are single, less than 2 to 3 centimeters in diameter and are raised less than 1 centimeter above the surfaces of the surrounding integument. Some of the lesions are present at birth, others appear very shortly thereafter.

The important decision for the dermatologist to make is whether to treat the birthmark or to leave it alone and thus rely upon spontaneous resolution. Experience has proven over years of clinical observation that natural obliteration of a large percentage of these new growths can be expected. Since all blemishes will not vanish untreated, each child born with one or the child who subsequently develops the type of birthmark under consideration, should be put under the observation of a dermatologist within a very few days of its discovery.

A thorough questioning of one or both of the parents should be made at the time of the first observation to determine their belief whether the angioma is growing or if it is stationary. If growth is agreed upon, treatment should be instituted at once. By doing so, a great advantage is obtained.

Next comes to mind the question of how much and how extensive the treatment should be after the decision to institute it. This conclusion is very readily reached. It can be decided by observation. When the dermatologist and parents have agreed upon the fact that all growth has ceased, treatment should be discontinued. From then on natural resolution will carry to the ultimate goal, the banishment of the lesion. Active therapy is not necessary to the point of total obliteration.

EXTENT OF TREATMENT

Inasmuch as these tumors are benign, conservative treatment should be used. Sub-erythema dosages of radium or x-ray should be used at intervals spaced to prevent damage to the skin, subcutaneous structures or tissues. If any scar or other sequela is present upon completion of treatment, it should be from the angioma itself and not from the treatment. No permanent areas of alopecia in the scalp, telangiectasia, or atrophy of the skin should be found from irradiation. There should be no scars caused by the use of improperly placed sclerosing solution.

Submitted January 10, 1953.

EVALUATION

Many practitioners dismiss these lesions with a wave of the hand thinking they have treated the condition amply or that nature will care for all of them. This conclusion is not often accepted by the parents. Very frequently they seek another practitioner who refers them to a dermatologist. Sometimes through friends and relatives they finally consult one. In some cases, parents seek the dermatologist's advice on their own initiative.

The parents need assurance the baby is absolutely normal, though he has a birthmark. They need to be assured the baby does not have cancer because of their possible belief that every tumor may be a cancer. They need assurance that a good cosmetic result can and will be obtained without disfiguration or painful sequela, especially in girl babies. Every parent wants his child to be perfect, hence the desire for the removal of the birthmark as promptly and painlessly as possible. Parents wish to see no evidence of an imperfect baby and also want the child to know nothing of his "birthmark."

A dermatologist can, in the vast majority of instances, meet all these demands if given the opportunity to evaluate these cases early and treat them according to the method he has found most efficacious in his experience.

The Author

● Dr. Mercer, Ft. Wayne, Indiana, is a member of courtesy staff at Methodist, Lutheran, and St. Joseph Hospitals.

Low Fat-Low Cholesterol Diets

Do low fat-low cholesterol diets satisfy the requirements of an adequate diet? Most do not but can be made to do so. The ordinary lipid-poor diet causes constipation or diarrhea, much gas and poorly formed stools. The patient does not feel well on the diet.—Edward L. Bortz, M. D., Philadelphia; *J. Lancet,* 73:93, March, 1953.

Large Twins — A Case Report with Review of Other Cases

ANSEL WOODBURN, M. D.

WHEN a baby is born, the mother's first question is, usually, "What is it?," and the second one, "What does it weigh?" Thus there seems to be a natural interest in the size of the newborn.

Twins are usually thought of as smaller than single babies. That this is true is shown by the fact that in the literature are reports of only 24 cases of twins whose combined weights were 7,000 grams, (about 15½ pounds) or more.

The most comprehensive study of large twins was made by Albert Mathieu of Portland, Oregon, and reported in *Northwest Medicine*, in May, 1938. He not only reviewed the literature, but acquired information from heads of obstetrical departments in a number of large hospitals, through personal communications. The total number of cases of twins he could find weighing 7,000 grams or more totalled 20, to which he added one case of his own, in which the combined weight of the twins was 7,880 grams.

Of these 21 cases four weighed more than 8,000 grams. Data regarding them are shown in the following table I:

TABLE I

Obstetrician	Sex	Individual Weights	Combined Weights
		Grams	Grams
M.Schulze	not mentioned	4,500-3,650	8,150
Ross	Male	4,217-3,940	8,157
Holzapfel	male	4,670-4,510	9,180
Warren	male	8,164-7,938	16,102

Since 1938 three more reports of large twins have been made, as follows: Croft reports twin girls weighing 8 lb. 11 oz. and 8 lb. 13 oz., a combined weight of 7,847 Gm.;[1] Summers reports twin girls weighing 8 lb. 12½ oz. and 8 lb. 4½ oz., a combined weight of 7,725 Gm.;[2] and Dring reports twin boys weighing 10 lb. ¼ oz. and 8 lb. 3 oz., a combined weight of 8,250 Gm.[3]

Thus in the literature are reports of only five pairs of twins whose combined weight was more than 8,000 Gm.; including one pair of such Brobdingnagian size (16,102 Gm. or 35.5 lb.) that reasonable doubt can be felt as to their authenticity.

FOURTH LARGEST TWINS REPORTED

For the sake of record, I am reporting the birth of twin boys weighing 9 lb. 3½ oz. (4,182 Gm.) and 8 lb. 13¾ oz. (4,018 Gm.), a combined weight of 8,200 Gm., and who are the fourth largest twins reported in the literature.

Submitted February 25, 1953.

The Author

● Dr. Woodburn, Urbana, Ohio, is a member of the obstetrical staffs of Mercy Memorial Hospital, Urbana; and Champaign County Hospital, Urbana; on courtesy staff at Mercy Hospital, Springfield; and Springfield City Hospital.

CASE REPORT

The patient, a white woman, aged 33, was in her eighth pregnancy. In October, 1948, I had delivered her of a girl baby weighing 9 lb. 2 oz., and in December, 1949, of a boy weighing 8 lbs. Both of these babies were in right occipitoposterior positions and rotated and delivered spontaneously.

She presented herself in this pregnancy May 20, 1952. Her last menstruation began November 8, 1951, and her calculated date of delivery was August 15, 1952. Examination showed her to be six months pregnant, and her weight was 243 pounds—less than she weighed in 1948 at the same period of her pregnancy.

Her pregnancy was uneventful, and at term she weighed 257 pounds.

Delivery occurred August 31, 1952, at the Champaign County Hospital. Labor had started at 11 p. m., August 30th. The first twin, a boy, was delivered at 3:12 a. m. by spontaneous rotation from a right occipitoposterior position. He weighed 9 lb. 3½ oz. The second twin, also a boy, delivered spontaneously from the same position (R. O. P.) at 3:20 a. m. His weight was 8 lb. 13¾ oz.

These boys were not identical, one being dolichocephalic, the other one brachycephalic.

The placentas were contiguous and appeared as one and delivered spontaneously at 3:30 a. m. There was no abnormal postpartum bleeding.

SUMMARY

The birth of twin boys with a combined weight of 8,200 grams is reported. Search of the literature shows reports of only three other cases of twins whose combined weight was greater. Of these, one pair reported was of such enormous weight that their authenticity may be questioned.

In my case, pregnancy and labor were without any of the complications often associated with twins.

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Difficulties in the Evaluation of the Results of Psychotherapy and Implications for Referring Physicians

BERNARD S. MATTHEWS, M. D.

THE psychiatrist has asked himself and is frequently asked by others, referring physicians, social agencies, social scientists, and patients, what exactly are the results of treatment by psychiatric interviewing? How much does one accomplish? What can one expect? What are the statistics?

A good friend and colleague with a fine, scientifically disciplined mind not too long ago berated psychiatrists rather severely to me for not having the concrete answers to these and many other similar questions. Partly as a result of the prevailing vagueness in this regard, referring physicians are understandably perplexed about the problem and consequently some have too great expectation while others are unduly pessimistic.

My friend is, of course, correct; meaningful facts and figures are not available, although a number of attempts to garner them have been made and reports are in the literature. (See Bibliography.) Of these probably the most definitive is that by Dr. Robert P. Knight.[1] In this article Dr. Knight summarizes the results reported of almost a thousand cases treated at the Berlin Psychoanalytic Institute, the London Clinic of Psychoanalysis, the Chicago Institute for Psychoanalysis, and the Menninger Clinic. While these cases were treated specifically by the psychoanalytic method, the difficulties involved in evaluating the results are essentially the same as with any other psychotherapeutic method.

Why is the problem so difficult? The answer is that there are so many variables to be taken into consideration; indeed so many that what relevant facts and statistics are available are subject to the need of considerable interpretation and evaluation, and so become of very limited value for communication to those who most need the answers.

CONSIDERATION OF VARIABLES

What are some of these variables to be considered? Essentially they are:

(1) What is the nature of the psychiatric problem?

(2) What sort of person has the problem?

(3) What is the current reality situation, that is, the entire individual socio-economic setting?

(4) What is the anticipated goal?

(5) What are the personal qualifications, training, and experience of the therapist?

(6) What is the general therapeutic method employed?

One readily realizes that each of these variables is in turn immensely complicated. Let us touch upon some of the facets relevant to each, and attempt to illustrate the critical significance of some of these with a few case studies.

The nature of the problem must encompass the clinical diagnosis, its duration, and its severity. The "rub" here is that few psychiatric syndromes appear in "pure culture." For example, a patient's diagnosis may be "Anxiety Reaction" but there well may be obsessive-compulsive features, perhaps certain mild paranoid trends, etc. Certainly one must remember that, just as any two persons' fingerprints differ, individual variations between two persons carrying the same diagnostic classification are of such striking importance as to make the nosological categories themselves of relatively limited value for meaningful statistical evaluation. One must assess the entire personality structure of the given individual; the degree of maturity; the amount of talent—native or developed and this, of course, including the degree of intelligence; the ability to verbalize; the extent of real desire for help or change; the degree of ability to enter into a constructive emotional relationship with the therapist.

REALITY SITUATION

The current reality situation encompasses such consideration as the familial, marital, professional, and financial circumstances of the patient. The attitudes of friends, family, and family physician are of considerable importance and may either contribute to a favorable outcome or constitute actual interference.

Financial considerations may realistically limit

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Submitted February 1, 1953.

the individual's opportunities to effect specific changes in his general situation during treatment. Furthermore, a patient may have insufficient funds to even afford the required method of treatment, or else may be so wealthy, and accustomed to unchallenged authority as a result of this wealth, that this may almost paradoxically constitute an obstacle in the treatment relationship.

The family constellation is, of course, of critical significance. For example, a woman having an unsatisfactory relationship with her husband but having four or five children presents quite a different problem from an essentially similar situation where the couple is childless. The intricacies of the reality situation are really so manifold that again no two cases are truly even nearly similar.

ANTICIPATED GOAL

As to the goal, what are to be the criteria of a successful outcome? At times the end-point would seem to be a rather sharp one—for example, the alleviation of a specific presenting complaint—but most often the difficulties are multiple, and the presenting complaint is but the presenting "point" of a deep and extensive abscess. Increasingly referrals to psychiatrists are not at all for an isolated difficulty, such as a phobia or an hysterical pain or paralysis, but for complex disorders of adjustment and failures in interpersonal relationships—so-called character disorders. Similarly, psychosomatic disorders relate to the entire personality structure of the individual.

What shall be the yardstick by which to measure success, and who shall make the measurements? The patient? The psychiatrist? The family? Some patients will be satisfied with relatively limited improvements, while others will be grossly dissatisfied. Families very often are not in a position to adequately judge since they are themselves emotionally involved with the patient and may actually respond negatively to what the psychiatrist may consider an improvement in the patient. Psychiatrists themselves often disagree as to what constitutes a real or significant improvement, or certainly as to degree of improvement, and similarly as to what constitutes a failure.

In this area attempts have been made to standardize criteria,[1] but inevitably the psychiatrist's subjective evaluation and interpretation limit the objectivity. Clinical psychologists have attempted to achieve "objective" evaluations through the use of the Rorschach (ink-blot) test and other similar psychological tests, but thus far these efforts have been experimental and the results require further critical study.

THE THERAPIST

The matter of qualifications of the therapist would seem to be roughly measurable, but is it quite? Actually, not too readily at all for here is encompassed the entire matter of the personality of the therapist, and no matter what the specific method, how scientifically oriented, psychotherapeutic interviewing remains very much an art, a matter of sensitivity and intuitiveness—gifts to be counted as much, or perhaps even more, than training or experience and difficult to measure.

Differences in the personalities of various psychiatrists undoubtedly account for the fact, for example, that a specific psychiatrist may be very successful with a certain general type of patient and do comparatively less well with another type, while another psychiatrist will fare quite oppositely. This is, of course, true in general medical practice as well and is a recognized principle in non-medical fields, undoubtedly underlying the principle of the salesman's "turnover" in high-pressure retail selling.

THERAPEUTIC METHOD

There is, then, the matter of psychotherapeutic method. Probably there are as many methods as there are therapists. Even with so-called classical or orthodox psychoanalysis for example, standardized as many may assume the method to be, and probably the most standardized of any existing method, the variations in techniques are quite marked.[4] The admixture of other methods—the degree of employment of suggestion, support, advice, goal-setting, encouragement, acceptance, and criticism is a matter that varies from therapist to therapist. Needless to say, one method or combination often fails with a specific case where another may succeed.

Under this question of method an important item that should be considered is that of duration and frequency of treatment. One cannot generally have the same expectation from relatively brief psychotherapeutic work when patients are seen only once or twice a week, as compared with the two to four years of a typical psychoanalysis with its three to six interviews a week. Another complicating factor involved in this connection is that the sheer passage of time, or so-called "tincture of time" principle, may operate. Some psychiatric illnesses undoubtedly are somewhat self-limited, and too, over a period of time many important changes may occur outside of treatment in the patient's life which may critically influence the course of therapy in one manner or another.

Let us consider now a few cases in order to illustrate some of the points we have described. In each case summary just enough material is presented to the reader to give some "feeling" about the case.

CASE PRESENTATIONS

Case I. This patient was a 38 year old married woman referred by her physician with the pre-

senting complaint that for a period of about a month unwelcome thoughts had been constantly impinging themselves upon her consciousness. These thoughts were of a sexual and aggressive nature. She often looked at members of her family, including her husband and two small children, and thought of an axe buried in their heads. She looked at men's pelvic areas and the thought of fellatio occurred. She looked at women's buttocks and thought of the word "tickle." At times she looked at a tree and "imagined" that it had male genitalia as its fruit.

The patient's appearance, general content of thought, aside from the foregoing, and emotional responsiveness were not particularly unusual. She was moderately tense and quite dismayed by her symptoms. She appeared to be a rather reserved person but was able to verbalize fairly well after some initial embarrassment.

The patient gave a history of a somewhat similar, though less troublesome, episode some five or six years previously with spontaneous remission after a period of several weeks. Her general adjustment as a housewife and mother had been fairly good. She had always been a rather compulsive housekeeper and quite meticulous about her personal hygiene. She had tended to be somewhat ruminative and worrisome. It was felt that of primary importance in the precipitation of her present illness were certain difficulties in relation to her husband—a considerably hostile, dictatorial, and demanding fellow against whom the patient had always been almost entirely unable to take a stand. The acute illness apparently began when the husband bought a new home of which the patient disapproved.

The patient had told her husband of her thoughts, and he had told her of women who do practice fellatio and who have sexual affairs with other women. He labelled such women collectively as "queers," all of which made the patient wonder if she were a "queer."

Significant in the patient's background were a rather severe religious training, a dominating, restrictive mother, little or no early sexual information or training, and an episode of mutual masturbation with a girl her age when the patient was ten years old, about which she had often thought with considerable guilt.

DISCUSSION

While the symptomatology and personality traits of the patient in this case suggest the possibility of a diagnosis of Obsessive-Compulsive Neurosis, one senses that the presenting complaints may indicate an even more disruptive process. The patient had to a certain extent lost the ability to adequately deal with certain strong impulses. The manner of "breaking through" of the rather primitive aggressive and "alien" sexual impulses suggests the possibility of a pre-psychotic condition or of an actual psychosis.

No simple diagnostic category would be specifically descriptive; however, a clinical evaluation, indicating the presence of a psychotic process, immediately limits the method that most psychiatrists would contemplate employing in the treatment of the case and also, of course, considerably modifies the goal of treatment.

It can be recognized that this patient presented a number of assets for psychotherapy. Both age and intelligence were in her favor. While her previous life adjustment had not been entirely unmarked by difficulties, still she had not done too badly. She had been able to marry and to have children and to generally lead a fairly normal life. She had been able to spontaneously recover from a previous mental upset which was not too dissimilar from that of the present illness. Furthermore she was able to readily accept the psychological origin of her illness and was, in comparison to many patients, very much interested in receiving treatment and related well to the psychiatrist.

In this case there seemed to be the potentiality for helping to strengthen the patient to deal with her troublesome impulses, particularly to help her better understand some of the hostile feelings which appeared to be of primary causal importance in the etiology of her present illness. In such a case, however, one would wish to tread very slowly and softly, therapeutically speaking, avoiding much in the way of probing and rather proceeding by considerably supporting the patient, educating, and encouraging.

However, even if the patient were helped to rid herself of her troublesome thoughts, would we then consider her "well" and, if so, to what extent? One would wonder how much it would take to precipitate a recurrence.

This particular woman did have a remission of her symptomatology after a period of about two and a half to three months of treatment. It was felt that although treatment had been helpful, it was impossible to ascertain the exact extent of the role of the psychotherapy in bringing about this remission, since so many other factors were operative. Obviously there is much danger in such a case of falling into a post hoc, ergo propter hoc fallacy and crediting the therapy too much. It would be equally fallacious to underestimate the meaningfulness of the treatment to such a patient.

Case II. This patient was a 29 year old married man who sought psychiatric treatment on his own. His presenting complaint was that he had been unable to make a satisfactory job adjustment. He had also been subject to periods of mild depression.

The patient was a quite good-looking young man who was a college graduate. Despite better than average intelligence, he was employed at a simple and routine job in a factory. He had quit several higher paying jobs with much more future after rather angry differences with his bosses. He was chronically dissatisfied but at the same time rather unambitious. He dreamed of success but was unable to work concertedly toward that end. He was envious of friends and relatives who had been given many material things by their parents and others, and had long been bitter and critical, particularly toward his father.

The patient's father was a considerably successful business man. His relationship with his

son had always been a poor one. The father had been an autocratic master of his home and intolerant and impatient with his children. The patient never remembered having been praised for a job well done. He generally complied with his father's dictatorial commands but with a quiet sullenness and unhappiness.

The patient had recognized before coming to seek psychiatric treatment that his relationship to his father might well have influenced his relationships with bosses and some of his general attitudes about work, success, marriage, etc.

DISCUSSION

Here we deal with a general personality or character problem. Such a patient would constitute a good candidate for a thorough psychoanalysis, but the patient's financial ability and the qualifications of available therapists may interdict such a therapeutic program. The available therapist will then have to do the best he can to help the patient understand the basis of some of his self-defeating attitudes and to help him with some of the difficulties in his interpersonal relationships.

In this case in contrast to the first, one would wish to employ, and must be adequately trained and capable of employing, an uncovering, interpretative psychotherapy.

Again the evaluation of the efficacy of the treatment may be difficult. One may see apparent improvement in certain areas of the patient's adjustment and continued failures in other areas. Furthermore, where the patient does improve, it may be difficult to conclude how permanent the result may be, that is, how long after the termination of the therapeutic relationship the patient will be able to maintain his improvement.[5]

Case III. This patient was a 32 year old married woman who was referred by her family physician because of a mild, anxious depression of short duration. She had been sleepless and had kept her husband awake telling him the details of a recent limited sexual experience with her employer and recounting some of her relationships with men in her past, previous to her marriage. She was tense, tearful, guilt-laden, and remorseful.

The patient was a college graduate and was of superior intelligence. She had been a very efficient and successful assistant to her employer, an unhappily married executive of a large organization, a man in his late forties. Working together closely they had become more and more involved emotionally, their relationship culminating in sexual experiences short of actual coitus, which patient could not bring herself to permit. During the patient's six years of marriage there had been no other extramarital experiences, and premarital experience had in reality been quite limited.

The patient's sexual adjustment with her husband had apparently been fairly good, but a prominent difficulty had been the patient's inability to become pregnant. Repeated medical examinations found her fit, but her husband was said to have a "low sperm count." The patient felt, furthermore, that her husband was not aggressive enough in general and that he seemed to have some rather "feminine ways."

DISCUSSION

Here we deal with a rather acute and recent illness of not too great severity and apparently related to a specific difficulty in the patient's relationship to her husband. Here one may contemplate the possibility of rather limited goals, based upon further exploration of the patient's attitudes and feelings about her husband, perhaps particularly about his apparent inability to impregnate her. Connecting this difficulty with her extramarital experience and clarifying the neurotic origin of her behavior may better enable her to understand what has happened, therefore ameliorating guilt and anxiety.

Again the therapeutic goal and the criteria for success in treatment may vary considerably. One therapist may consider it enough to see the patient less troubled with anxiety. Another may feel that a complete exploration of the patient's personality is indicated, with certain basic character changes being essential to a "successful" outcome. In such a case as this, as in most, events, reactions, attitudes outside the treatment situation must be taken into account in assessing the role of the treatment per se. For example, the husband's attitude about the wife's extramarital relationship may, of course, be critically important in determining the eventual outcome.

CONCLUSIONS

What conclusions may we draw from all of this? Certainly one sees that one deals here with complexities which do not readily lend themselves to mathematical or statistical-type evaluation. There are some psychiatrists who feel that with refinement in the methods of reporting cases and the establishment of standard criteria for evaluation, it will one day be possible to produce valid statistical-type conclusions. Miles and Finesinger[2] state, ". . . It is believed that further progress in solving the problem awaits more detailed investigations and methodologic advances in the analysis of data."

On the other hand, many would agree with Freud who in the *New Introductory Lectures*[6] commented on the statistics on therapeutic results gathered at the Berlin Clinic by saying, "But such statistics are not instructive, because the material with which they deal is so heterogeneous that it would need a very large number of cases to prove anything. It is better to examine one's own individual experience . . ."

For the present at least it seems that realistic prognostication in regard to therapeutic possibilities must come from the given psychiatrist with an awareness of his own capacities and potentialities and after the opportunity for a preliminary study of a given case.

I believe it is fair to say that, in general,

psychotherapeutic interviewing provides a helpful and constructive experience for the patient. This general statement can be related to the dictum said to have been given by Hippocrates, "He cures in whom one has confidence." One may think essentially of the patient coming to treatment being in some sort of trouble, and akin to a child seeking help from a parent. If the patient finds in the physician a good parent who both supports him and helps him to grow, then the patient must benefit. It is upon this basic foundation that the validity of all psychotherapy depends.

To have such a generally favorable attitude toward the results with psychotherapy, however, is a far cry from claiming to have specific statistical validation. Since such validation is not really available it is suggested that we not delude ourselves or others but think along with that wise man who said, "If we cannot see clearly, let us at least see what is unclear clearly," i. e., let us not use or depend upon figures which at best satisfy our need for neatly tied packages, empty though they actually may be.

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Differential Diagnosis

Mercurial diuretics, in addition to producing the low salt syndrome, more frequently cause hypochloremic alkalosis, superficially resembling the low salt picture, but less serious and requiring different treatment, and the two conditions should be sharply differentiated.

During the use of mercurial diuretics, chloride is carried off in large amounts, and as the serum level falls, the CO_2 naturally increases to compensate, and hence the name "hypochloremic alkalosis." A reasonable approximation of the serum sodium concentration at any time here or in any condition without renal insufficiency can be obtained by adding the CO_2 in millimols per liter (NOT in vols. %) to the chloride in mEq, plus the additional factor of 12 to allow for other acid ions such as sulfates, phosphates, etc.

In contrast, the low salt state may have the same chloride level, but CO_2 is generally NOT increased and the serum sodium is lowered, resulting in hypotonic extracellular fluid.—Charles M. Ballentine, M. D., Atlanta; *J. M. A. Georgia*, 42:84, February, 1953.

Some Aspects of Control of Trichinosis

The high incidence of trichinosis in the United States, as indicated by various research studies, has caused the United States Public Health Service to inaugurate an active trichinosis program patterned after the ideas of foremost investigators of this disease. Due to the recent nationwide epidemic of vesicular exanthema, a virus disease of swine, interest and support have been created for trichinosis control, since the prevention of both diseases is primarily dependent on the disinfection of all garbage fed to swine.

The Public Health Service is undertaking to control the disinfection of garbage shipped interstate by instituting enforcement action under the Section of the Interstate Quarantine Regulations which prohibits garbage to be shipped across state lines and fed to swine unless minimum heat-treatment of garbage (212°F. for 30 minutes) is obtained.

Since little information was available, because of the scarcity of garbage heat-treatment plants in this country, the U. S. Department of Agriculture and the U. S. Public Health Service, as part of a cooperative program, have prepared a joint publication on the various methods now in use to disinfect garbage.

The health and agriculture authorities of the states are being urged to adopt uniform legislation or regulations and to institute control programs to insure the disinfection of all garbage fed to swine. A suggested guide for state legislation, which was developed and distributed to state authorities by the U. S. Department of Agriculture and U. S. Public Health Service, will require all swine-raisers feeding commercial garbage to adopt disinfecting procedures and to obtain licenses or permits. (A copy of *Suggested Guide for Drafting a State Act Regarding Feeding Untreated Garbage to Swine* may be obtained by writing to the author.)

In the past few months, new legislation or regulations have been adopted in two states and the Territory of Alaska, while between 15 and 20 states are reported to be preparing legislation for consideration in the coming sessions of their legislatures.—Ralph J. Van Derwerker, chief, Municipal Sanitation, U. S. Public Health Service, Washington, D. C.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

Improved Tuberculosis Prognosis

Streptomycin and PAS are not bacteriocidal but bacteriostatic. They do not cure or eradicate the disease. Relapses occur and reconversion of sputum from negative to positive is frequent. They have markedly improved the prognosis of tuberculosis but have not controlled it.—John H. Skavlem, M. D., *W. Va. Med. J.*, Dec., 1952.



Case Record

From the
Institute of Pathology, Western Reserve University, and University Hospitals of Cleveland

Edited Under the Auspices of the Ohio Society of Pathologists

Robert Ritterhoff, M. D., President

Presented by Richard D. Moore

THE patient was a white male, 29 years old, who had been known to have a lymphoblastic lymphosarcoma for the past five years. The diagnosis had been made by cervical lymph node biopsy. During the course of his illness, the patient was treated with x-ray irradiation and nitrogen mustard.

One month before death the patient had completed a 24 day course of roentgen therapy to lymph nodes in the inguinal region, the abdomen and the neck. One week after the completion of this treatment, he developed shaking chills, pain and burning on urination, urgency, frequency and nocturia. The patient found his temperature to be 40°C. These symptoms continued until admission one week later. At the time of admission to the hospital, he had a temperature of 39.8°C. He also complained of a hacking nonproductive cough.

Physical Examination: The patient had a blood pressure of 118/70, a pulse rate of 108 per minute, and a respiratory rate of 24 per minute. The head, eyes, ears, nose and mouth were negative. There was pigmentation of the skin of the neck from irradiation. The lungs were clear and the heart normal. The liver and spleen were palpable, as were a few small discrete axillary and inguinal lymph nodes. There was no costovertebral angle tenderness or pain on pressure in the suprapubic region. There was a left hydrocele. Rectal examination was negative. The neurological examination was normal. The extremities showed no abnormalities.

Laboratory Findings: The admission laboratory examinations showed a slight albuminuria and 10 to 25 white blood cells per high power field in the urine. The hemoglobin was 12.5 grams; red blood cell count 4,200,000; white blood cell count, 3,250; and, a normal differential. Blood cultures and urine cultures showed no growth of organisms. The stools were normal. The serology was negative. X-rays of the lungs and genitourinary system were negative.

Hospital Course: The patient continued to have chills and fever. The temperature rose to 40°C. daily. Antipyretics and antibiotics had no effect on the temperature. Acid fast stains of sputum were negative for tubercle bacilli.

The patient subsequently received courses of nitrogen mustard and x-ray. These had no effect on the temperature. Following the mustard therapy the patient had a progressive fall in hemoglobin to 7.4 grams, and white blood count to 475. He was given transfusions of blood on several occasions, and at the time of death the hemoglobin was 8 grams and the white blood cell count 2,250.

The clinical diagnosis was lymphosarcomatosis.

POSTMORTEM EXAMINATION

Autopsy revealed widespread histoplasmosis. There was lymph node enlargement, but no evidence of lymphosarcoma in any of the lymph nodes or other tissues of the body. The lymph nodes consisted of dense hyalinized connective tissue and very few cells.

The histoplasma infection involved lungs, trachea, liver, pancreas, duodenum, colon, kidneys, bladder, adrenals, spleen, lymph nodes and bone marrow. The organisms occurred principally in macrophages, but were also seen free in the tissues. There was no evidence of any other tissue reaction to the organisms.

In view of this diagnosis, the original biopsy of the cervical lymph node was reviewed, and the diagnosis of lymphoblastic lymphosarcoma was confirmed.

DISCUSSION

The question of the source of the infecting organism cannot be answered. There was no

evidence of any previous old infection. This, then, could represent the initial infection, or altered reactivity of the host to an already existing lesion, resulting in wide dissemination throughout the body.

Nitrogen mustards have been shown in experimental animals and man to produce fall in antibody titers or prevent their elevation. Also they have been reported to increase the susceptibility of animals and man to infections, and often by organisms which are not usually considered pathogenic.[1, 2] In addition, the mustards have a marked effect on the tissues of the reticulo-endothelial system, and consequently on the body's cellular defense mechanisms. There is a marked decrease in the cells of the lymphocytic and myelocytic series. This mode of action is thought to be a toxic one, in which certain enzyme systems of the cell are inactivated.

Since both x-ray and nitrogen mustard have the potentialities of destroying antibodies and ability to form antibodies, as well as damaging the reticulo-endothelial system, the acute course is explained.

It has also been noted by Miller, Keddie, Johnstone, and Bostick[3] that histoplasmosis complicating lymphosarcoma, Hodgkin's disease and leukemia is not rare.

It is also of interest that there was no evidence of the primary disease, lymphosarcoma, at the time of the autopsy. This raises the question of whether the patient was cured of the lymphosarcoma, or whether the lymphosarcoma remained a localized disease and the tissue changes noted at the time of autopsy are the result of irradiation or long standing histoplasmosis, which terminally was reactivated.

SUMMARY

This is the case of a 29 year old white male with lymphosarcoma, which was treated with x-ray and nitrogen mustard. He died of a febrile illness, which was found to be histoplasmosis at the time of autopsy.

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Lipemia and Atherosclerosis

There is an extraordinarily wide variation in the lipemia developed in some people on a high fat-high cholesterol diet as compared with others. Whether these are the people who will develop atherosclerosis remains to be seen.—Edward L. Bortz, M. D., Philadelphia; *J. Lancet*, 73:93, March, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Insect—This word is short for the Latin term "animal insectum" and is used to designate the largest class of the Phylum Arthropoda and includes every animal having a segmented body and jointed appendages. Insects were so named because the bodies of many of them appear to be cut into or almost divided into parts. The word insect is derived from the Latin "in" or into, plus "seco," I cut.

Tea—When this beverage first became known in about the third or fourth Century, it was being used in China as a medicine and was called "tscha." By about the 6th Century it became a common beverage in China and later spread to Persia. In 1379 Christopher Borough, an English traveler, introduced it into England. The name "tscha" changed along with the spread of the tea drinking habit and thus we had the Arabian "shay," the Persian "cha," the Russian "chai" and the Dutch "thee" from which the English word "tea" supposedly came.

Inquest—Coming from the Latin words "in" or into and "quaro," meaning, "I seek or look for," this term now designates an official inquiry into the cause of death. The inquest comes down to us from an early date in English history, where it was originally a body of men impaneled to look into and secure information on any matter of fact. However, custom and time has limited the term, especially in America, to mean a Coroner's inquiry or inquest.

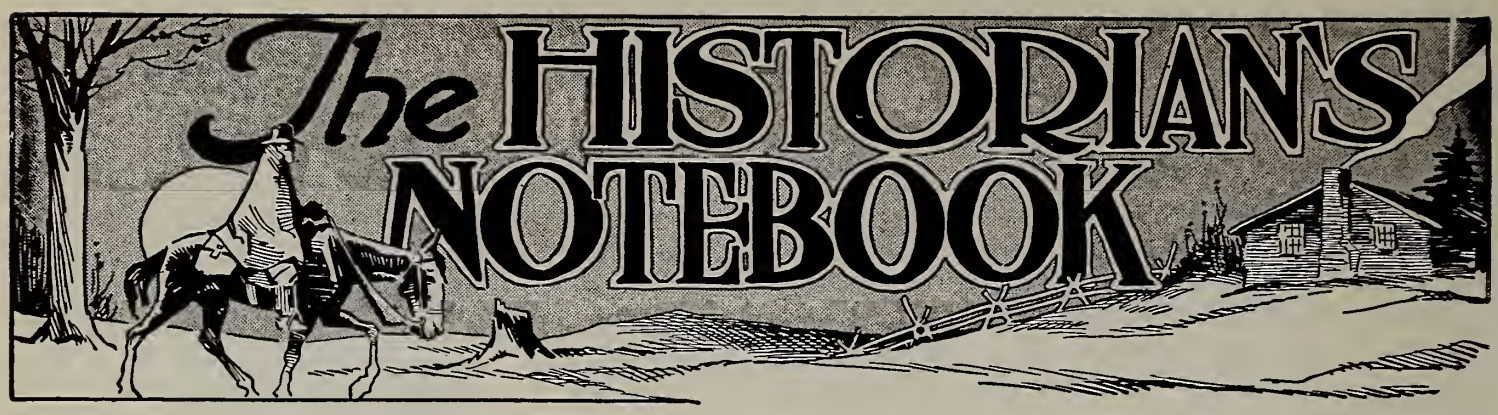
Tattooing—This procedure of puncturing the skin and rubbing in a colored substance so as to produce permanent pictures and designs is Polynesian in origin. The term is derived from the Tahitian word "tatau," from "ta" a mark.

Parasite—This word is still used in its original Greek meaning which was "para," or beside, and "sitos" or food, literally meaning one who eats at the table of another. Thus it is someone who lives at another's expense, whether it is a person, an animal or a plant. The term was first used in English in the biological sense in about 1727.

Infant—Quite naturally an infant is unable to speak and this word actually designates "one who is not speaking." It is derived from the Latin prefix "in" or not, plus the Latin word "fans" or speaking.

Dose—When you are sick the doctor "gives" you a measured portion or "dose" of medicine. This is the literal meaning of the word dose, which is derived from the Greek word "dosis" meaning a giving and in turn comes from the Greek "didonai" meaning to give.

—Harry Wain, M. D., Mansfield, Ohio.



The Blue Soldier—His Health—His Physicians

CLARK P. PRITCHETT, M. D.

PART II

(Concluded from May issue)

SURGERY DURING THE WAR

DESPITE earnest application and commendable progress, surgery in the Union Army during the Civil War was often painful and barbarous. Serious operations were sometimes performed by men sadly deficient in professional skill.

Choloroform was widely used as an anesthetic and ether to a lesser extent, but sometimes neither was available and patients had to submit to the most painful operations without deadening influence except such as could be obtained from a bottle of whiskey. When anesthesia was available some soldiers refused it for fear of never regaining consciousness, but medical records show relatively few cases of death from anesthesia alone.

Army surgeons argued long and earnestly over the relative merits of amputation. Piles of severed arms and legs about field hospitals after any battle testified to a large membership in the school of the saw. But the frequency of gangrene, even in minor injuries, gave considerable support to advocates of radical surgery.

Sometimes soldiers slated for loss of a member took things into their own control. An artillery corporal wounded in the knee at Hatcher's Run on being told that his leg must come off borrowed a pistol from his comrade and put it under his pillow. When the surgeon came to take him to the operating room the Yank drew the gun and exclaimed: "The man that puts a hand on me dies."

The surgeon was momentarily taken aback, but recovering his poise he tried to convince the soldier that his only hope of survival lay in parting with the injured leg. The corporal adamantly held that if he died he wanted to take both limbs with him to the Promised Land. Finally the doctor, losing his patience, exclaimed: "Let the d—— fool keep it and die." Since the story as here told was first related by the soldier himself, it goes without saying that he kept both his life and his leg.

Ignorance was a prime factor in the deplorable conditions which prevailed in Union Hospitals. A Federal surgeon, who lived through the revolution in medical science which came in the half-century following Appomattox, in 1918 spoke thus of his Civil War experience:

"We operated in old blood-stained and often pus-stained coats, the veterans of a hundred fights. . . . We used undisinfected instruments from undisinfected plush-lined cases, and still worse, used marine sponges which had been used in prior pus cases and had been washed only in tap water. If a sponge or an instrument fell on the floor it was washed and squeezed in a basin of tap water and used as if it were clean.

"Our silk to tie blood vessels was undisinfected. . . . The silk with which we sewed up all wounds was undisinfected. If there was any difficulty in threading the needle we moistened it with . . . bacteria-laden saliva, and rolled it between bacteria-infected fingers. We dressed the wounds with clean but undisinfected sheets, shirts, tablecloths, or other old soft linen rescued from the family ragbag. We had no sterilized gauze dress-

The Author

● **Dr. Pritchett, Columbus, is assistant clinical professor, the Ohio State University College of Medicine.**

Read before the January, 1953, meeting of the Kit Kat Club, Columbus, Ohio.

ing, no gauze sponges. . . . We knew nothing about antiseptics and therefore used none."

Little wonder that gangrene, tetanus and other complications were so frequent and that slight wounds often proved mortal.

THE AGONY OF WAR

One of the most brilliant of war correspondents of the Civil War was George Alfred Townsend, reporting for the *New York Herald.* His description of the wounded in McClellan's campaign on the peninsula is one of the most graphic descriptions of the agony of the war I have ever read. I quote:

"I rode across the fields to the Hogan, Curtis, and Gaines mansions; for some of the wounded had, meantime, been deposited in each of them. All the cow-houses, wagon-sheds, hay-barracks, hen-coops, Negro cabins, and barns were turned into hospitals. The floors were littered with 'corn-shucks' and fodder; and the maimed, gashed, and dying lay confusedly together. A few, slightly wounded, stood at windows, relating incidents of the battle; but at the doors sentries stood with crossed muskets, to keep out idlers and gossips.

"The mention of my vocation was an 'open sesame,' and I went unrestrained into all the largest hospitals. In the first of these an amputation was being performed, and at the door lay a little heap of human fingers, feet, legs, and arms. I shall not soon forget the bare-armed surgeons, with bloody instruments, that leaned over the rigid and insensible figure, while the comrades of the subject looked horrifiedly at the scene.

"The grating of the murderous saw drove me into the open air, but in the second hospital which I visited, a wounded man had just expired, and I encountered his body at the threshold. Within, the sickening smell of mortality was almost insupportable, but by degrees I became accustomed to it.

"The lanterns hanging around the room streamed fitfully upon the red eyes, and half-naked figures. All were looking up, and saying, in pleading monotone: 'Is that you, doctor?' Men with their arms in slings went restlessly up and down, smarting with fever. Those who were wounded in the lower extremities, body, or head, lay upon their backs, tossing even in sleep. They listened peevishly to the wind whistling through the chinks of the barn. They followed one with their rolling eyes. They turned away from the lantern, for it seemed to sear them.

"Soldiers sat by the severely wounded, laving their sores with water. In many wounds the balls still remained, and the discolored flesh was swollen unnaturally. There were some who had been shot in the bowels, and now and then they were frightfully convulsed, breaking into shrieks and shouts. Some of them iterated a single word, as, 'doctor,' or 'help,' or 'God,' or 'oh!'—commencing with a loud spasmodic cry, and continuing the same word till it died away in cadence. The act of calling seemed to lull the pain.

"Many were unconscious and lethargic, moving their fingers and lips mechanically, but never more to open their eyes upon the light; they were already going through the valley of the shadow.

"I think, still, with a shudder, of the faces of those who were told that they could not live. The unutterable agony; the plea for somebody on whom to call; the longing eyes that poured out prayers; the looking on mortal as if its resources were infinite; the fearful looking to the immortal as if it were so far off, so implacable, that the dying appeal would be in vain; the open lips, through which one could almost look at the quaking heart below; the ghastliness of brow and tangled hair; the closing pangs; the awful quietus. I thought of Parrhasius, in the poem, as I looked at these things:—

'Gods!
Could I but paint a dying groan.'—

And how the keen eyes of West would have turned from the reeking cockpit of the Victory, or the tomb of the Dead Man Restored, to this old barn, peopled with horrors.

"I rambled in and out, learning to look at death, studying the manifestations of pain,—quivering and sickening at times, but plying my vocation, and jotting the names for my column of mortalities . . ."

He continued further, "Ambulances, it may be said, incidentally, are either two-wheeled or four-wheeled. Two-wheeled ambulances are commonly called 'hop, step and jumps.' They are so constructed that the forepart is either very high or very low, and may be both at intervals. The wounded occupants may be compelled to ride for hours in these carriages, with their heels elevated above their heads, and may finally be shaken out, or have their bones broken by the terrible jolting. The four-wheeled ambulances are built in shelves, or compartments, but the wounded are in danger of being smothered in them.

"It was in one of these latter that I rode, sitting with the driver. We had four horses, but were thrice 'swamped' on the road, and had to take out the wounded men once, till we could start the wheels. Two of these men were wounded in the face, one of them having his nose completely severed, and the other having a fragment of his jaw knocked out. A third had received a ball among the thews and muscles behind his knee, and his whole body appeared to be paralyzed. Two were wounded in the shoulders, and the sixth was shot in the breast, and was believed to be injured inwardly, as he spat blood, and suffered almost the pain of death.

"The ride with these men, over 20 miles of

hilly, woody country, was like one of Dante's excursions into the Shades. In the awful stillness of the dark pines, their screams frightened the hooting owls, and the whirring insects in the leaves and tree-tops quieted their songs.

"They heard the gurgle of the rills, and called aloud for water to quench their insatiate thirst. One of them sang a shrill, fierce, fiendish ballad, in an interval of relief, but plunged, at a sudden relapse, in prayers and curses. We heard them groaning to themselves, as we sat in front, and one man, it seemed, was quite out of his mind.

"These were the outward manifestations; but what chords trembled and smarted within, we could only guess. What regrets for good resolves unfulfilled, and remorse for years misspent, made hideous these sore and panting hearts? The moonlight pierced through the thick foliage of the wood, and streamed into our faces, like invitations to a better life. But the crippled and bleeding could not see or feel it,—buried in the shelves of the ambulance."

LACK OF MEDICAL PERSONNEL AND FACILITIES

Once an army has taken the field no medical function is more important than care of the wounded. The injured must be gathered, transported to dressing stations, given surgical attention, and fed and cared for. They must be hospitalized within the army's lines or evacuated to some general hospital outside the combat area. The successful performance of these functions demands intricate organization, vast stores of goods, and a trained personnel. In 1861 all these were lacking.

New regiments formed brought volunteer surgeons into the service to whom army methods and army reports were mysteries. Medical officers often did not know what supplies were available or how to request them.

Early in the war most medical organization was on a regimental basis. There were no collecting companies, no medical regiments, and no evacuation hospitals. General hospitals of a sort existed but their location and function was poorly understood.

There was no trained medical personnel. The men assigned to the surgeons were usually musicians, invalids, or "gold bricks." They could be taken away from the medical officer at any time by the line officers.

Most supplies including ambulances, animals and tents were the property of the quartermaster and the quartermaster's corps was particularly reluctant apparently to give any equipment out for medical use.

Many generals were at cross purposes with their medical staffs. During Don Carlos Buell's command of the Army of the Ohio the medical department was "merely tolerated as an unpleasant necessity." The general resented the detailing of any men for hospital service since he believed "the Medical Department should be self sustaining—that the sick should care for the sick." Serious differences between medical officers and the line officers occurred as late as 1864.

General Halleck, who was Secretary of War Stanton's chief military adviser, was opposed to most of the proposals to improve the function of the Medical Department. The needed reform in getting adequate care and transportation for the wounded on the battle field was primarily the result of the efforts of Dr. Henry I. Bowditch of Boston.

AMBULANCE CORPS ACT OF 1864

His zeal was born of personal grief. His son had fallen wounded upon the battlefield, "and it is believed no one connected with an ambulance corps ever approached him there." Despite a serious abdominal wound Lieutenant Bowditch was brought off the field on a horse. When an ambulance at last reached him it was without water, and its driver would procure none. Young Bowditch died of his injury, and his father went into battle against the War Department's apathy. He never ceased his efforts until the Ambulance Corps Act of 1864 was on the statute books.

Dr. Bowditch opened his campaign with a visit to Surgeon General Hammond, who told him of his own repeated attempts to stir the War Department to action. As a civilian, Bowditch could do many things that would have been insubordinate in a surgeon general. He laid siege to General Halleck, who admitted that Stanton had left the ambulance corps matter up to him, and finally conceded that if General McClellan would write a letter asking for an ambulance corps he would consider that "sufficient to decide the matter of expediency."

With Olmsted's approval Bowditch then called on McClellan, who was most cooperative. He unhesitatingly signed a letter giving it as his opinion that a specially enlisted and specially trained hospital corps should be established for the whole Army.

The triumphant Dr. Bowditch, returning to Washington, called upon Stanton with two coworkers, a Mr. Pierce and a Mr. Welles. The Secretary of War promised to do exactly as Halleck might direct. He cheered his hearers by stating that he was willing even to authorize a draft on the Treasury, since he believed Congress would undoubtedly sustain any "humane proceeding."

But when Pierce called on Halleck he was coldly received. After reading McClellan's letter the general merely remarked: "Well, Mr. Pierce, you will please now send in your propositions in writing." When the shocked Pierce rejoined that, at the general's request, he had already

sent in well-written propositions three times, he was "sternly" told: "Send in your propositions in writing, Sir," and the interview was over.

Convinced now that the "faithless" Halleck deserved "the curses of all humane men," Dr. Bowditch turned his attention to promoting his ideas among the public. It took until 1864 to get the Ambulance Corps Act on the statute books.

Conditions under the first two surgeons general of the Civil War time, Lawson and Finley, caused the Medical Bureau to be characterized by the powerful *New York Tribune* as follows: "It is not accused of misfeasance or malfeasance, but of non-feasance. It seems to have done nothing since the war began. It is simply inefficient and inert, when inaction is the gravest of official misdemeanors."

REFORMS INITIATED

Through the tremendous efforts of the United States Sanitary Commission, a Medical Department Reform Bill was passed, in April, 1862, and a brilliant surgeon general in the person of William A. Hammond was appointed. Hammond initiated many reforms, the benefits of which we reap even to this day. Included among them was the establishment of an Army Medical Museum. Though he was courtmartialed in 1863 on apparently trumped-up charges, time has proven Hammond to be one of the great benefactors of soldiers the world over, in his own war and succeeding wars.

One of Hammond's accomplishments was the appointment of Jonathan Letterman as medical director of the army of the Potomac. Letterman set up a medical supply system, a medical evacuation system, a system of division hospitals, and provided for a division of labor among medical officers, which was gradually adopted throughout the Union Army. His system with some modification and change of name persisted, and served our armies in World Wars I and II, and has been copied by most armies of the world. The familiar pavilion type of military hospital was popularized by Letterman.

FEMALE NURSES

The role of female nurse in the Civil War was an interesting one. Apparently about 3,200 women served. The Civil War opened the gates of a great profession to women at a time when their economic opportunities were scarce. Dorthea Dix, renowned founder of insane asylums, was appointed to choose the "Female" nurses.

The candidates, each of whom was personally examined by Miss Dix, had to be past 30 years of age, healthy, "plain almost to repulsion in dress, and devoid of personal attractions."

Further requirements, as we are informed by a successful applicant, included knowledge of "how to cook all kinds of low diet" and renunciation of "colored dresses, hoops, curls, jewelry, and flowers on their bonnets." They must "look neat themselves, and keep their boys and wards the same. Must write and read for their boys, but not from any book or newspaper; must be in their own rooms at taps, or nine o'clock unless obliged to be with the sick; must not go to any place of amusement in the evening; must not walk out with any patient or officer in their own room except on business; must be willing to take the 40 cents per day that is allowed by the government, to assist them in supplying what the rations . . . will not furnish in food, and be ready to spend what is left of their salaries on the welfare of their patients."

U. S. SANITARY COMMISSION

The United States Sanitary Commission was far and away the most outstanding of volunteer benevolent organizations. Ably directed by Henry W. Bellows as president, Frederick Law Olmsted as general secretary and J. S. Newberry as secretary of the western department—all of whom were advised and actively supported by some of the country's most distinguished doctors and philanthropists—it co-ordinated and turned into useful channels the activities of hundreds of small groups.

The Sanitary Commission raised millions of dollars, purchased and distributed vast amounts of food, clothing, medicines and supplies, provided scores of nurses and doctors at critical times, and equipped, staffed and put into operation hospital boats, trains and numerous other facilities. Its agents conducted innumerable inspections, collected valuable data and kept the country informed as to the needs and conditions of the sick and wounded. Its usefulness was enhanced by its studied policy of conforming to military practices and winning the good will and support of responsible commanders.

Not the least of the contributions of the Sanitary Commission was the lead which it took in pointing up shortcomings and forcing corrective action. As already noted it was the moving spirit behind the house cleaning in high administrative circles in 1862 and the appointment of Hammond as Surgeon General. It also played a conspicuous part in modernizing the system of general hospitals and securing for the Medical Department adequate control over evacuation personnel, supply and transportation.

THE BALANCE SHEET

The medical and sanitary record of the Civil War was on the whole a good one. That this has not been generally realized is partly due to the fact that the Civil War took place at the very end of the medical "middle ages"—immediately before bacteriology and aseptic surgery made some of the war generation's triumphs seem piddling or irrelevant. Historians in general were uninterested in medical matters while medi-

cal historians preferred the biographical or "great man" approach.

From the standpoint of the man in uniform, the administrative reforms within the Medical Department were of great importance. In 1861, like all things military in the United States, that department was hopelessly amateurish, riddled with incompetence and thoroughly unprepared. By 1865 it was a large, smooth-functioning organization, spending more money than the Army had spent in the last year of peace, and controlling a system of hospitals more imposing than anything seen up to that time.

The field-relief system had evolved from the near-anarchy of regimental hospital and ambulance units to the integrated division and corps hospitals and ambulance trains. The medical supply system had evolved from a single distributing point and an annual issue, to a network of purveyors' depots throughout the country and a plan under which every unit was kept constantly supplied.

Through the Army, American doctors, for the first time, had the opportunity to organize and control large general hospitals. They had discovered, to their cost, that cleanliness was important, and that surgical infections might be kept from spreading if sanitary precautions were observed. They had found that women nurses could be of use; and the women, or at least the more perceptive among them, had learned that training and discipline are essential to the woman hospital nurse. Both doctors and nurses had learned that attention to the patient's morale is medically sound.

Through their work in the relief commissions, the civilians of the country had made substantial contributions to the spread of medical and sanitary knowledge, and to the distribution of much-needed supplies. On that base were to rise the American Red Cross and the other great voluntary associations which are so characteristic of the America of our day.

Whether the kind of surgical practice which war gives the already competent surgeon is valuable, may be argued. But it is impossible to deny that war experience made operating surgeons out of a large number of rural physicians who had in the past referred surgical cases to city specialists. In the spread of operational surgery which the "aseptic" era was soon to usher in, this training with the knife was important.

SANITARY REFORM ERA

The effect of the war upon the health of the men who participated was, on the whole, bad. Many a veteran carried with him for years, or for life, the sequelae of his army diseases. The population movements incidental to the war, and the return home of infected soldiery, seem to have had a deleterious effect on civilian health. Fortunately, however, the end result of the war experience was a preparation of both the medical mind and the public mind for the great era of sanitary reform.

The public health movement, which was to make such headway in the last third of the century, was evoked by the pressing needs of the fast growing cities and was aided greatly by yellow fever scares and cholera panics. But the men who led that movement were, in large part, the same men whose wartime experience as surgeons or Sanitary Commissioners had persuaded them of the interconnection of filth and disease. And the public with which they dealt was permeated with former soldiers whose recollections of the value of clean camps made them understanding cooperators in public health measures.

REFERENCES

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Commager, Henry Steel: The Blue and the Grey. Indianapolis, Ind., Bobbs-Merrill Co.

Leslie, Frank: The Soldier in Our Civil War. Columbian Memorial Edition, Edited by Paul E. Moltlay and T. Campbell Copland. New York, The Stanley Bradley Publishing Co., 1890.

Pott's Fractures

"No part of surgery is thought to be so easy to understand as that which relates to fractures and dislocations. Even the most inexpert and least instructed practitioner deems himself perfectly qualified to fulfill this part of the chirurtic art: And the majority, even of these, are affronted by an offer of instruction on a subject with which they think themselves already so well acquainted.

"This is also the opinion of a considerable part of the people. They regard bone-setting (as it is called) as no matter of science; as a thing which the most ignorant farriar may, with the utmost ease, become soon and perfectly master of; nay, that he may receive it from his father and family as a kind of heritage.

"This extension occasions the difficulty in reduction and the difficulty in keeping it reduced . . . but if the position of the limb be changed . . . with the knee moderately bent, the muscles forming the calf of the leg and those which pass behind the fibula and under the os calcis all are put into a state of relaxation and non-resistance, all this difficulty and trouble do in general vanish immediately; the foot may easily be placed right, the joint reduced, and by maintaining the same disposition of the limb, every thing will in general succeed very happily, as I have many times experienced." Thus wrote Percival Pott in 1768.—Lenox D. Baker, M. D., Durham, N. C.; *J. Florida M. A.*, 39:732, April, 1953.

Proceedings of The Council . . .

Combined Business and Social Meeting Held During Annual Meeting; Special Committee Appointments by Incoming President Approved

A REGULAR meeting of The Council of the Ohio State Medical Association was held at the Netherland Plaza Hotel, Cincinnati, Monday evening, April 20, following a dinner attended by members of The Council, A. M. A. Delegates, chairmen of State Association Committees and officials of the Cincinnati Academy of Medicine.

Following the introduction of guests by President Clodfelter, the minutes of the meetings of The Council held on March 21 and 22 were approved.

MEMBERSHIP STATISTICS

The Executive Secretary reported on membership as follows: Total State Association members as of April 17, 1953, 7,404; number of State Association members paying 1953 A. M. A. dues to date, 6,299.

The executive Secretary reviewed final arrangements for the 1953 Annual Meeting program starting on Tuesday, April 21.

The president read a letter from Dr. J. P. McAfee, Portsmouth, tendering his resignation as a member of The Council. By official action, Dr. McAfee's resignation was accepted with regrets and the Executive Secretary was advised to inform the Nominating Committee so that a successor could be elected by the House of Delegates during the Annual Meeting.

An amendment to its by-laws, adopted by the Scioto County Medical Society on April 13, 1953, was officially approved by The Council.

PUBLIC RELATIONS PROJECT

A communication from Dr. Earl D. McCallister, Columbus, secretary-treasurer of the Ohio Academy of General Practice, suggesting that the Ohio State Medical Association sponsor and finance a float for the Ohio Sesquicentennial parade in Columbus in commemoration of Dr. Edward Tiffin, first governor of Ohio, was read and discussed. By official action The Council voted to underwrite this project to the extent of $500.00, and that contributions from the Ohio Academy of General Practice toward the project would be accepted by the Association, if that organization voted to make such a contribution.

By a standing vote The Council expressed appreciation to Dr. Clodfelter for his work during the past year and congratulated him on a very successful term of office as president.

There being no further business, The Council then recessed to meet with the House of Delegates on Tuesday, April 21.

SESSION HELD ON APRIL 23

A special meeting of The Council of the Ohio State Medical Association was held on Thursday afternoon, April 23, at the Netherland Plaza Hotel, immediately following the final session of the House of Delegates of the 1953 meeting.

Dr. Paul A. Davis, the President, presented the following appointments to special committees, which were confirmed by The Council on motion duly made, seconded and carried:

Committee on Auditing and Appropriations—D. W. Heusinkveld, Cincinnati, chairman; R. J. Foster, New Philadelphia; Robert S. Martin, Zanesville.

Committee on Blood Banks—Horace B. Davidson, Columbus, chairman; Henry J. Caes, Dayton; Russell B. Crawford, Lakewood; Charles A. Doan, Columbus; John B. Hazard, Cleveland; Robert J. Ritterhoff, Cincinnati; H. Verne Sharp, Akron; Warren E. Wheeler, Columbus.

Committee on Chronic Illness — Harry V. Paryzek, Cleveland, chairman; H. W. Brettell, Steubenville; Ralph E. Dwork, Columbus; Gordon L. Erbaugh, Dayton; Jonathan Forman, Worthington; Joseph I. Goodman, Cleveland; Nelson D. Morris, Toledo; H. J. Nimitz, Cincinnati; Carl C. Nohe, Akron; Frank A. Riebel, Columbus; Stanley D. Simon, Cincinnati; John L. Stifel, Toledo. **Subcommittee on Cancer**—C. E. Hufford, Toledo, chairman; Arthur G. James, Columbus; John H. Lazzari, Cleveland; Frank T. Moore, Akron; W. D. Nusbaum, Lancaster; L. A. Pomeroy, Cleveland; A. E. Rappoport, Youngstown, Walter A. Reese, Middletown; Carl A. Wilzbach Cincinnati; W. E. Wygant, Mansfield. **Subcommittee on Mental Hygiene**—Dwight M. Palmer, Columbus, chairman; Edward O. Harper, Cleveland; Elmer Haynes, Toledo; Maurice Levine, Cincinnati; Roger E. Pinkerton, Akron; J. E. Sagebiel, Dayton.

Committee on Industrial Health and Workmen's Compensation—H. P. Worstell, Columbus, chairman; Warren A. Baird, Toledo; A. L. Berndt, Portsmouth; A. L. Bershon, Harold James, Dayton; Louis N. Jentgen, Columbus; Edmund F. Ley, Tiffin; Joseph Lindner, Cincinnati; R. L. Rutledge, Alliance; John M. Van Dyke, Canton; Rex H. Wilson, Akron; James N. Wychgel, Cleveland.

Committee on Legislation—Frank H. Mayfield, Cincinnati, chairman; W. W. Trostel, Piqua; Floyd M. Elliott, Ada; D. J. Slosser, Defiance; George W. Petznick, Cleveland; Wm. M. Skipp,

Youngstown; Jay W. Calhoon, Uhrichsville; James B. Johnson, Jr., Newark; Clyde M. Fitch, Portsmouth; Donald F. Bowers, Columbus; R. L. Mansell, Medina.

Committee on National Emergency Medical Service—Drew L. Davies, Columbus, co-chairman; C. C. Sherburne, Columbus, co-chairman; A. A. Brindley, Toledo, Robert Conard, Wilmington, Richard L. Meiling, Columbus, Herbert B. Wright, Cleveland, members-at-large. **Subcommittee on Civil Defense**—C. C. Sherburne, Columbus, chairman; E. E. Bauman, Warren, Drew L. Davies, Columbus; D. H. Downey, Dover; Marion G. Fisher, Oberlin; Charles H. Leech, Lima; F. B. Harrington, Steubenville; Richard Hotz, Toledo; L. L. Lawrence, Canton; A. M. Leigh, Cleveland; Harry R. Mendelsohn, Cincinnati; J. L. Morton, Columbus; Francis W. Shane, Gallipolis; Earl A. Simendinger, Akron; William R. Stewart, Marietta; Craig C. Wales, Youngstown; W. D. Welton, Dayton. **Military Advisory Subcommittee**—Drew L. Davies, Columbus, chairman; Robert Conard, Wilmington, member-at-large; David A. Tucker, Jr., Cincinnati; Homer D. Cassel, Dayton; Lester C. Thomas, Lima; A. A. Brindley, Toledo; Donald M. Glover, Cleveland; R. L. Rutledge, Alliance; Albert E. Winston, Steubenville; Walter L. Cruise, Zanesville; C. L. Pitcher, Portsmouth; E. L. Montgomery, Circleville; Charles R. Keller, Mansfield.

Committee on Rural Health—J. Martin Byers, Greenfield, chairman; L. E. Anderson, Greentown; Byron B. Blank, DeGraff; E. G. Caskey, Mineral Ridge; Jonathan Forman, Worthington; V. R. Frederick, Urbana; Carl F. Goll, Hopedale; L. W. High, Millersburg; H. R. Mayberry, Bryan; Carll S. Mundy, Toledo; W. L. Murphy, Cardington; H. T. Pease, Wadsworth; J. I. Rhiel, Port Clinton; James M. Snider, Marysville; G. N. Spears, Ironton; H. K. Van Buren, Carey; D. S. Williams, Marietta; E. K. Yantes, Wilmington; Kenneth Taylor, Pickerington.

Committee on School Health—H. B. Thomas, Gallipolis, chairman; Charles T. Atkinson, Middletown; Walter Felson, Greenfield; W. F. Galbreath, Findlay; Charles F. Good, Cleveland; L. A. Hamilton, Athens; Earl E. Kleinschmidt, Wooster; Robert M. Lemmon, Akron; T. L. Light, Dayton; Harold C. Messenger, Sr., Xenia; Gordon B. Munson, Dayton; Margaret O'Neal, Zanesville; J. M. Painter, Kent; Thomas E. Shaffer, Columbus; D. L. Steiner, Lima; J. W. Wilce, Columbus; Carl A. Wilzbach, Cincinnati; C. W. Wyckoff, Cleveland.

Committee on Medical Care of Veterans—Edgar Northrup, Marietta, chairman; L. D. Allard, Portsmouth; Robert A. Breckenridge, Cuyahoga Falls; Lewis W. Cellio, Columbus; Robert L. Eastman, Mt. Vernon; W. W. Green, Toledo; Harry R. Huston, Dayton; Henry W. Lehrer, Sr., Sandusky; S. W. Ondash, Youngstown; Charles L. Shafer, Mansfield; T. H. Vinke, Cincinnati.

Woman's Auxiliary Advisory Committee—John S. Hattery, Mansfield, chairman; C. A. Gustafson, Youngstown; James R. Jarvis, Van Wert.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Dr. Bauer Addresses Public Health Association in Columbus

Dr. W. W. Bauer, director of the Bureau of Health Education, American Medical Association, was the featured speaker on the program of the Annual Conference of the Ohio Public Health Association, held in Columbus, April 9 and 10.

Dr. Bauer discussed the subject, "How the Local Health Department and Physicians Can Work Together." He was introduced by Dr. John D. Porterfield, director, the Ohio Department of Health.

At the same meeting Dr. Bauer appeared before a joint session of the Administration and the Health Education Sections to talk on the subject, "Effective Use of Health Education Materials and Techniques."

Discussants of his address were Dr. Harry Wain, Mansfield, health commissioner of Mansfield and Richland County, and Mr. Sewall O. Milliken, chief, Division of Health Education, Ohio Department of Health.

Mr. Hart F. Page, assistant director of public relations, Ohio State Medical Association, presided over the session of the health education section.

Proposed New Rules Governing T. B. Hospitals To Be Heard, June 20

Certain amendments to the regulations of the Ohio Sanitary Code, governing tuberculosis hospitals of Ohio, have been adopted by the Ohio Public Health Council and, in accordance with law, will be submitted to a public hearing in Hearing Room No. 3, Ohio Departments Building, Columbus, on June 20, 1953, at 10:00 A. M., E. S. T.

Physicians and others interested in the management and operation of a tuberculosis hospital may wish to review the amended regulations and may wish to attend the public hearing on them.

Copies of the proposed regulations have been sent to all local health commissioners, county commissioners, county clerks and local tuberculosis hospital superintendents. Interested persons may review the regulations in the offices of the above officials or may secure a copy of the regulations by writing to the Ohio Department of Health, Columbus 15, Ohio.

House of Delegates . . .

Business Transacted at Two Sessions Held in Connection with 1953 Annual Meeting, Cincinnati; Officers Elected; Committees Named

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the 1953 Annual Meeting of the Ohio State Medical Association, April 21-23, was held in the Restaurant Continental, Netherland Plaza Hotel, Cincinnati, Tuesday afternoon, April 21, at 4 o'clock.

The meeting was called to order by Dr. Daniel E. Earley, President of the Cincinnati Academy of Medicine, who extended a cordial welcome to the delegates and then introduced the President, Dr. H. M. Clodfelter, Columbus.

Dr. Clodfelter then presented his presidential address. **(See pages 538-540 in this issue for Dr. Clodfelter's address.)**

The House of Delegates then proceeded with scheduled business. The first item was approval of the minutes of the meetings of the House of Delegates held at the 1952 Annual Meeting in Cleveland. On **motion** duly made, seconded, and **carried**, the minutes **were approved** as published in *The Ohio State Medical Journal.*

GUESTS INTRODUCED

The following guests were introduced and recognized by the House of Delegates with applause: Mr. Thomas A. Hendricks, secretary, Council on Medical Service, American Medical Association; Mr. J. P. Sanford, executive secretary of the Kentucky State Medical Association; Mr. James A. Waggener, executive secretary of the Indiana State Medical Association; Mr. Craig Wright, senior, Ohio State University College of Medicine, and winner of the first Ohio State Medical Association rural medical scholarship four years ago; Mr. Joseph Mullen, representative of the Ohio State University College of Medicine Student A. M. A.

Dr. Leonard Stack, Lorain, chairman of the Reference Committee on Credentials of Delegates, then reported to the House of Delegates that the credentials of 118 delegates and 12 officers and members of The Council, a total of 130, had been approved by the committee and that these delegates had been seated.

REFERENCE COMMITTEES

President Clodfelter then named the following reference committees:

Credentials of Delegates—Leonard Stack, Lorain, chairman; C. T. Atkinson, Middletown; Carl C. Nohe, Akron; Paul F. Orr, Perrysburg.

President's Address—R. W. Holmes, Chillicothe, chairman; R. M. Andre, Waverly; H. C. Messenger, Xenia; Robert C. Rothenberg, Cincinnati; R. L. Rutledge; Alliance; D. J. Slosser, Defiance.

Resolutions—G. A. Woodhouse, Pleasant Hill, chairman; John H. Budd, Cleveland; Floyd M. Elliott, Ada; J. A. Fraser, East Liverpool; W. W. Green, Toledo; Charles W. Pavey, Columbus; A. C. Ormond, Zanesville; George N. Spears, Ironton; N. P. Stauffer, Millersburg; J. D. Stires, Malvern; E. K. Yantes, Wilmington.

Tellers and Judges of Election—T. L. Light, Dayton, chairman; Carl F. Goll, Hopedale; S. W. Ondash, Youngstown; Ray M. Turner, Springfield; E. B. Young, Lima.

NOMINATING COMMITTEE CHOSEN

The next order of business was the nomination and election of a Nominating Committee as follows:

First District—Foster M. Williams, Cincinnati, temporary chairman.
Second District—Ray M. Turner, Springfield.
Third District—Frank M. Wieseley, Findlay.
Fourth District—David C. Frick, Toledo.
Fifth District—George W. Petznick, Cleveland.
Sixth District—Wm. M. Skipp, Youngstown.
Seventh District—G. A. Foster, Coshocton.
Eighth District—R. G. Plummer, Newark.
Ninth District—R. M. Andre, Waverly.
Tenth District—Wm. F. Bradley, Columbus.
Eleventh District—E. J. Meckstroth, Sandusky.

RESOLUTIONS INTRODUCED

President Clodfelter then called for the introduction of resolutions. Seven resolutions were presented and automatically referred to the Reference Committee on Resolutions. **(See minutes of Second Session for text of resolutions and action thereon.)**

Under new business the House of Delegates ratified the action of The Council approving the reissuance of a copy of its original charter to the Tuscarawas County Medical Society.

The House then recessed for dinner and until Thursday, April 23, for another business session.

MINUTES OF SECOND SESSION

The House of Delegates convened for the second and final session, Thursday afternoon, April 23, following a luncheon in Parlors A, B, C, D, Netherland Plaza Hotel, Cincinnati.

Dr. Leonard Stack, Lorain, chairman of the Committee on Credentials, reported that 97 delegates and 11 officers and members of The Council had submitted their credentials; that such creden-

tials had been approved; and that 108 delegates, officers and Councilors had been seated.

President Clodfelter introduced Dr. James L. Whitehill, president-elect of the Medical Society of the State of Pennsylvania, and he was recognized with applause. Mr. Craig Wright, senior at Ohio State University College of Medicine and holder of one of the Ohio State Medical Association rural medical scholarships, was recognized. Mr. Wright thanked the House of Delegates for the privilege of attending the Annual Meeting and expressed appreciation to the Association for the financial assistance made available to him through the scholarship.

Reports of the Reference Committees were then called for by the President.

Dr. R. W. Holmes, Chillicothe, chairman of the Committee on President's Address, submitted the following report, which was **approved** on **motion** duly made, seconded and **carried:**

REPORT ON PRESIDENT'S ADDRESS

"The Reference Committee on President's Address congratulates Doctor Clodfelter upon his ability to keep his rear view mirror and windshield clean and so bring us, his passengers, safely through another year.

"Certainly we have come to the end of a year full of hazards without any serious wreck, nothing in fact, more distressing than small tire leaks which have been promptly vulcanized.

"Our President is to be commended for the clear and forceful way he has discussed the responsibilities of our County Societies. The committee agrees with him in his statement that the success of our State Society depends almost exclusively upon the proper functioning of our component societies. If we develop active civic leadership in problems affecting the health and welfare of our local communities, we will succeed.

"Doctor Clodfelter brings to our attention the important functions of the State Organization, develops the importance of its work, its continuing success, the zeal and intelligent and often exhausting labors of our Councilors and committees. He pays high and deserving tribute to the full time executives and their staff. To all of this, your committee is in unanimous agreement.

"Your committee appreciates the opportunity the President's Address has given all of us to learn of the conference he had with the commission to study the health needs of the nation. We hope that demonstration of organized medical effort in behalf of improved medical care has contributed to the establishment of a new cabinet post.

"Doctor Clodfelter has reminded us of our responsibilities along many lines and your committee approves of his desire to stimulate our efforts in behalf of such matters as universal peace, world economics, scientific advancements and finally the very important requirements in the physicians of the future.

"Finally, your committee moves the adoption of this report and by so doing gives its approval to a distinguished gentleman for a job well done."

ACTION ON RESOLUTIONS

The report of the Committee on Resolutions was presented by Dr. G. A. Woodhouse, Pleasant Hill, chairman of that committee.

Dr. Woodhouse advised the House of Delegates that his committee had given consideration to each of the seven resolutions presented at the first session of the House of Delegates. He stated that various members of the House of Delegates and other interested members of the Association had attended the meeting of the committee and were helpful to the committee in forming its conclusions.

The report stated that Resolution A, which had been presented by Dr. Wm. M. Skipp, Youngstown, and Resolution D, presented by Dr. Richard L. Meiling, Columbus, had been considered jointly inasmuch as they pertain to the same subject. Resolution A and Resolution D, as presented, read as follows:

RESOLUTION A

"WHEREAS: Discrepancies on the procurement of physicians for the Armed Services are apparent and taking cognizance of the new bill to renew the Doctors' Draft Law as proposed by the Defense Department, therefore

"BE IT RESOLVED, That

"(1) The age limit be retained at 51 years.

"(2) That an orderly procedure be followed in the call of physicians for the Armed Services according to recently adopted standards.

"(3) That the call be in reverse order of that in effect now, calling up the oldest first (all in priority 3) so that they may serve in peacetime and thus form a pool of younger men for wartime duty.

"(4) That physical standards be sufficiently lowered for physicians so that defects allowing a normal civilian practice be waived, so that stations in non-combat zones can be manned by such personnel, thus releasing fully fit men for duty in combat areas and that physicians now disqualified be re-examined.

"(5) That there is to be no deferment of essentiality.

"(6) That Allied Veterans of World War II have the same status as American Veterans.

"(7) That any doctor able to carry on civilian practice is capable of serving in the Armed Forces.

"(8) That the new law be so written that local and State Advisory Committee be given authority.

RESOLUTION D

"WHEREAS, The physicians of Ohio are sincerely interested in seeing that the mem-

bers of the armed forces are provided with the best possible medical care, and

"WHEREAS, They also are sincerely interested in the proper utilization of medical manpower in order that the civilian population likewise will have adequate medical care and treatment during this period of national emergency,

"BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association in session, April 21, 22 and 23, 1953, in Cincinnati, Ohio, endorses the following recommendations for meeting this national issue:

"1. Legislation should be enacted by the Congress providing for the extension of Public Law 779 (The Doctors' Draft Law) in amended form.

"2. Inasmuch as the enactment of Public Law 779 was accomplished to meet the immediate needs of the armed forces at the beginning of the Korean affair, with full cognizance that such legislation was discriminatory in character, extension of the Doctor Draft Law should be limited to one year, namely to July 1, 1954.

"3. Because the more than 30,000 physicians registered in Priorities 1, 2 and 3 are more than adequate to meet the medical manpower requirements of the armed forces for the period of July 1, 1953, to July 1, 1954, physicians who have had active duty (as defined by law) since September 1, 1939, in the United States armed forces and those of our allies during World War II, should not be held liable for registration and induction under the Doctors' Draft Law or to involuntary recall to active duty, except those physicians who are currently classified in Priority 1 and Priority 2.

"4. Any legislation enacted should specifically extend the primary obligation of physicians now classified in Priorities 1 and 2, who are not called into service before July 1, 1953, the current expiration date of Public Law 779.

"5. A 12 months' period of service should be established for those physicians who have had at least 12 months prior military duty since September 16, 1940.

"6. Any new legislation enacted should obligate physicians covered by the basic Selective Service Act (P. L. 51—82nd Congress), known as the Universal Military Training and Service Act, for military service without permitting deferments because of dependency or marital status.

"7. Provision should be made for the recognition of military service since September 1, 1939, with countries which were allies of the United States during World War II and this provision should be made retroactive to September 9, 1950, the effective date of Public Law 779.

"8. The present maximum age incorporated in the Doctors' Draft Law, namely, registration at age 50; obligation to serve until age 51, should be preserved.

"9. The present concept of deferring physicians regardless of their priority classification if they are essential to the national health, safety or interest should be continued.

"10. Legislative authority to establish national and state medical advisory committees to the Selective Service System should be continued.

"11. In an effort to insure a more equitable utilization of medical manpower by the armed services, it is recommended that there be established a position as Assistant Secretary of Defense for Health Affairs. It appears that the proper way to provide for this would be by amendment to the National Security Act of 1947, as amended. In this connection, it is believed that a continuing, concerted effort should be made to effect a lowering of the present ratio of 3.0 physicians per 1000 troops.

"12. Equalization pay of $100.00 a month should be provided by legislation for all physicians who enter on active duty in the armed forces and the U. S. Public Health Service, except those who may be inducted under the Doctors' Draft Law.

"FURTHER, BE IT RESOLVED, That copies of this statement should be transmitted immediately to Ohio's members of the Congress, Senators Taft and Bricker, and members of the Armed Services Committees of the House and Senate.

RECOMMENDATIONS OF COMMITTEE

Commenting on the two resolutions, the committee report said:

"It is the opinion of your committee that Resolution D covers all the basic points which should be considered in connection with this issue. Moreover, the committee was not in agreement with several recommendations made in Resolution A. Therefore, your committee recommends the adoption of Resolution D."

On motion duly made, seconded and unanimously carried, the recommendation of the committee approving Resolution D was ratified.

The Reference Committee stated that in order to dispose of Resolution A the committee recommended that Resolution A be tabled.

On motion duly made, seconded and carried, the recommendation of the committee, that Resolution A be tabled, was approved.

RESOLUTION B

The Reference Committee on Resolutions stated that Resolution B, presented by Dr. Richard D. Bryant, Cincinnati, and reading as follows, had the unanimous support of the committee and

that the committee recommended that it be adopted:

"WHEREAS, The medical profession is vitally concerned with maternal health and welfare, and

"WHEREAS, Improvement in the care of mothers must be based on adequate knowledge of difficulties which arise, and

"WHEREAS, Knowledge of the causes of maternal deaths is a basic factor in determining what improvement in maternal care is necessary,

"THEREFORE BE IT RESOLVED, That the Council of the Ohio State Medical Association be directed to appoint a committee, composed of members of the Obstetrical and Gynecological Societies of Ohio and representatives of other interested medical groups, to explore, in cooperation with local boards of health and the Department of Health of the State of Ohio, the feasibility of establishing a Committee on Maternal Deaths, whose function would be to study, analyze and report on all maternal deaths in Ohio."

During the discussion of the committee's recommendation an amendment was presented from the floor that the words "and general practitioners" be inserted between the words "Gynecological" and "Societies" in order to provide that representatives of the general practitioner group shall be named on the committee provided for. On motion duly made, seconded and **carried**, the recommendation of the committee, approving Resolution B as amended, was ratified.

RESOLUTION C

Resolution C, which was presented by Dr. Robert C. Rothenberg, Cincinnati, read as follows:

WHEREAS, It is assumed that every elected delegate to the Ohio State Medical Association annual meeting desires to do a conscientious job with full integrity; and

WHEREAS, Only a few of the resolutions to be introduced in the House of Delegates are submitted for perusal in advance, leaving many resolutions to be verbally stated at the first of the two meetings of the House, without full opportunity for most of the delegates to study the content of these resolutions and to digest it thoroughly; and

WHEREAS, This situation could be rectified by putting printed copies of all resolutions into the hands of all delegates between the two meetings of the House of Delegates, now, therefore

BE IT RESOLVED: That a copy of every resolution submitted to the House of Delegates at the annual meeting of the Ohio State Medical Association be presented in printed (mimeographed) form to every delegate before action is taken upon the resolution.

The report of the Reference Committee on Resolution C was as follows:

"Your committee is in agreement with the purposes of this resolution. It suggests minor changes in the wording of the final paragraph by deleting the word 'presented' in lines 3 and 4 of that paragraph and the substitution of the words 'made available,' and by adding the following words after the word 'resolution' in lines 5 and 6—'whenever feasible'."

On **motion** duly made, seconded and **carried**, the recommendation of the committee, that Resolution C be approved as amended by the committee, was ratified.

RESOLUTION E

Resolution E, which was presented by Dr. George A. Woodhouse, Pleasant Hill, read as follows:

"WHEREAS, There is now pending before the Congress proposals to modify the present law relating to medical and hospital benefits for veterans, and

"WHEREAS, Congress also has under consideration measures pertaining to the furnishing of medical and hospital care for the dependents of military and other government personnel, and

"WHEREAS, These questions are of major importance to all parties directly concerned and to the nation as a whole, and

"WHEREAS, In the opinion of the House of Delegates of the Ohio State Medical Association, the American Medical Association should as soon as possible establish definite policies regarding the attitude of the medical profession on these issues, in order that members of the Congress may be advised of the views of the medical profession pertaining to such issues,

"BE IT RESOLVED:

"1. That the House of Delegates of the Ohio State Medical Association, in session April 21, 22 and 23, 1953, in Cincinnati, Ohio, re-affirm policies on these questions adopted by previous Houses of Delegates and The Council of this Association, as follows:

"The Ohio State Medical Association believes that veterans, the same as all other citizens, are entitled to adequate medical and hospital care of the highest quality.

"Ex-service men and women, whose disabilities are the direct result of military service, should be provided with such care at the expense of the Federal Government through the facilities of the Veterans Administration.

"Ex-service men and women, whose disabilities are of non-service connected origin and who cannot themselves meet the costs of

necessary medical and hospital care, should be provided with such care at public expense but such care should be supplied through regular state and local agencies established for such purposes.

"The Ohio State Medical Association believes that the dependents of military personnel and civilian employees of the armed forces, the same as all other citizens, are entitled to the adequate medical and hospital care of the highest quality.

"Such dependents and civilian employees should be cared for by medical officers of the armed forces only in cases of emergency or in military areas where proper and adequate services cannot be supplied by civilian physicians and adequate hospital services cannot be furnished by civilian hospitals.

"Such dependents and civilian employees who cannot themselves meet the costs of necessary medical and hospital care, or who do not have benefits provided by voluntary medical and hospital insurance programs, should be provided with such care at public expense. Care furnished to them at public expense should be supplied through regular state and local agencies established for such purposes.

"Physicians should be encouraged to discuss with the members of the armed forces and their families, their economic status, and endeavor to work out with them a financial arrangement which would not impose a hardship on such families, even to the extent of providing services without reimbursement should that be necessary.

"2. That this House of Delegates instruct Ohio's delegates to the American Medical Association to present these recommendations to the House of Delegates of the American Medical Association at the annual session of the American Medical Association in New York City, June 1-5, 1953."

The report of the Resolutions Committee on this resolution read as follows:

"Resolution E was presented by the chairman of your Resolutions Committee and delegate from Miami County. During the discussion of this resolution by your reference committee, it was emphasized that the questions covered by the resolution are of major importance, not only to the medical profession but to the nation as a whole. The purpose of the resolution is to convey to the House of Delegates of the American Medical Association the views and opinions of the Ohio State Medical Association on these questions and to stimulate definite action at the earliest possible date by the House of Delegates of the American Medical Association on these matters. The Reference Committee heartily endorses this resolution and recommends its adoption."

On motion duly made, seconded and carried, the recommendation of the Reference Committee, that Resolution E be adopted, was ratified.

RESOLUTION F

Resolution F, presented by Dr. Joseph Lindner, Cincinnati, read as follows:

"WHEREAS, the county medical societies of the State of Ohio are collecting American Medical Association dues, which are, in turn, certified to the Ohio State Medical Association for recertification to the American Medical Association; and

"WHEREAS, the procedure of dues collection for the American Medical Association involves considerable additional expense for county medical societies, thereby creating an extra financial burden and the expenditure of funds collected from members of local medical societies, some of whom are not members of the American Medical Association; and

"WHEREAS, the officers of the local county medical societies are compelled to use the funds collected as dues from all members of their society for expenditures incurred in behalf of the American Medical Association, now therefore

"BE IT RESOLVED: That the Ohio State Medical Association request an adequate allowance of funds from the American Medical Association in order that local county medical societies may be reimbursed for the expenditures incurred in the collection of dues for the American Medical Association."

Dr. Woodhouse reported the action of the Resolutions Committee as follows:

"The committee, by a majority vote, approved the resolution with the following amendment: That the final paragraph of the resolution be deleted and the following paragraph be substituted:

" 'Be It Resolved, That the Ohio State Medical Association request the American Medical Association to reimburse state medical societies annually in an amount of not less than 3 per cent of the total amount of A. M. A. dues remitted by them annually to the A. M. A. in order that local medical societies may be reimbursed, on request, for expenditures incurred by them in collection of A. M. A. dues.' The committee recommends the adoption of Resolution F, as amended."

A motion was made and seconded that the report of the Resolutions Committee, recommending the adoption of Resolution F, as amended, should be ratified. There was a lengthy discussion. Dr. C. C. Sherburne of Columbus moved that the recommendation of the committee on Resolution F be laid on the table. The motion was seconded and carried by a majority vote. Therefore, Re-

solution F and the recommendation of the committee were laid on the table.

RESOLUTION G

Resolution G, presented by Dr. S. L. Burkhardt, Steubenville, read as follows:

> "BE IT RESOLVED: That assignments or payments from the Ohio Medical Indemnity, Inc., be made to the subscribers' physicians or to the subscriber and his physician as co-assignees."

Following is the statement of the Reference Committee regarding Resolution G:

"Your committee was advised that Ohio Medical Indemnity has no legal authority to pay benefits to a physician directly, inasmuch as Ohio Medical Indemnity contracts are specific contracts between O. M. I. and the individual subscriber.

"The committee was advised that at the present time, when properly drawn assignment blanks, carrying the signatures of the subscriber and the physician, are received by Ohio Medical Indemnity, the name of the physician as well as the name of the subscriber are carried on the check issued for payment of the indemnity. Such checks must be endorsed by both the subscriber and the physician.

"For reasons stated above, the committee recommends that this resolution not be adopted."

On **motion** duly made, seconded and **carried,** the recommendation of the committee, that Resolution G not be adopted, was ratified.

On **motion** by Dr. Woodhouse and seconded by many, the report of the Reference Committee as a whole on the seven resolutions, as amended, **was approved** and adopted.

ELECTION OF PRESIDENT-ELECT

The President then called for nominations from the floor for the office of president-elect.

Dr. R. D. Dooley, Dayton, was recognized and he placed in nomination the name of Dr. Merrill D. Prugh, Dayton, a member of The Council from the Second District.

There being no other nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were ordered closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for the election of Dr. Prugh to the office of president-elect. This was done and the President declared Dr. Prugh elected as president-elect.

Dr. Dooley and others escorted Dr. Prugh to the platform. Dr. Prugh made a brief talk, stating that he would make every possible effort to fulfill the obligations and duties of this high office.

ELECTION OF COUNCILORS

Dr. Foster M. Williams, Cincinnati, chairman of the Committee on Nominations, then submitted the following report for that committee:

FOURTH DISTRICT

As Councilor for the Fourth District, the committee placed in nomination the name of Dr. Paul F. Orr, Perrysburg, to succeed Dr. Carll S. Mundy, Toledo, who had completed three consecutive terms on The Council and who, under the Constitution and By-Laws, was not eligible for renomination and re-election. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Orr. This was done and Dr. Orr was declared officially elected to The Council for the years 1953 and 1954.

SIXTH DISTRICT

As Councilor for the Sixth District, the Committee placed in nomination the name of Dr. Carl A. Gustafson, Youngstown, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Gustafson. This was done and Dr. Gustafson was declared officially elected to The Council for the years 1953 and 1954.

EIGHTH DISTRICT

As Councilor for the Eighth District, the committee placed in nomination the name of Dr. Robert S. Martin, Zanesville, to succeed himself for a term of two years. Dr. Martin had been serving the unexpired term of Dr. C. P. Swett, Lancaster. There being no further nominations, on **motion,** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Martin. This was done and Dr. Martin was declared officially elected to The Council for the years 1953 and 1954.

TENTH DISTRICT

As Councilor for the Tenth District, the committee placed in nomination the name of Dr. E. H. Artman, Chillicothe, to succeed Dr. Wm. F. Mitchell, Columbus, who had advised the committee not to place his name in renomination. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Artman. This was done and Dr. Artman was declared officially elected to The Council for the years 1953 and 1954.

NINTH DISTRICT

The committee reported that due to the resignation of Dr. J. P. McAfee, Portsmouth, as Councilor of the Ninth District, and which resignation had been accepted by The Council with regret, the committee desired to place in nomi-

nation the name of Dr. Carter L. Pitcher, Portsmouth, to serve the unexpired term of Dr. McAfee, namely, for one year. There being no further nominations, on **motion** duly made, and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Pitcher. This was done and Dr. Pitcher was declared officially elected as Councilor of the Ninth District for the unexpired term of one year.

NEW SECOND DISTRICT COUNCILOR ELECTED

The committee also reported that it had intended to place in nomination the name of Dr. Merrill D. Prugh, Dayton, to succeed himself as Councilor of the Second District, but that this would not be possible now, inasmuch as Dr. Prugh had been elected by the House of Delegates as president-elect.

On recommendation of the Nominating Committee, the President called for nominations from the floor for the office of Councilor for the Second District. Dr. A. W. Carley, Dayton, placed in nomination the name of Dr. George A. Woodhouse, Pleasant Hill. The nomination was seconded by many. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Woodhouse. This was done and Dr. Woodhouse was declared officially elected to The Council for the years 1953 and 1954.

A. M. A. DELEGATES ELECTED

The Committee on Nominations then presented the following nominations for the office of delegate and alternate to the American Medical Association to be filled at this year's meeting, such delegates and alternates to start their terms January 1, 1954, and to serve for two years, namely, the calendar years 1954 and 1955:

Dr. A. A. Brindley, Toledo, delegate, and Dr. Joseph C. Lindner, Cincinnati, alternate.

Dr. L. Howard Schriver, Cincinnati, delegate, and Dr. E. O. Swartz, Cincinnati, alternate.

Dr. C. C. Sherburne, Columbus, delegate, and Dr. Richard L. Meiling, Columbus, alternate.

There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for the foregoing nominees. This was done and they were declared duly elected delegates and alternates to the American Medical Association for two-year terms starting January 1, 1954.

DR. DAVIS INSTALLED

President Clodfelter then turned over the gavel to Dr. Paul A. Davis, Akron, and installed him as President of the Association.

Dr. Davis made a brief talk to the House of Delegates in which he outlined the following twelve-point program as suggestions to members and objectives of his administration for the ensuing year:

"1. Practice good ethical medicine.

"2. Clean our own house by disciplining those M. D.'s, few in number, who are tarnishing the reputation of the whole profession by their unethical acts.

"3. See that the public is protected so that they can always obtain the services of good physicians.

"4. Revitalize our county societies and make them leaders in their communities on all health and civic movements where the health and care of the public is concerned.

"5. Work with rural communities to establish facilities for physicians, so that a better distribution of physicians and medical care is available.

"6. Devote some of your time to public-patient relationship.

"7. Extend public health coverage to areas lacking it and give good medical care to the indigent and chronic invalid.

"8. Continue to give active support to our voluntary medical insurance program, so that it can provide benefits for many more citizens of Ohio.

"9. Work for better care of the physically handicapped and then return to self-support.

"10. Inculcate the newly-trained physician in the traditions and ethics of good medicine.

"11. Support any good ethical medical activity if it is of value to the health and welfare of the public.

"12. And finally, be more active in your county, state and national medical organizations."

Dr. Davis then announced the appointment of the following constitutional committees:

COMMITTEES APPOINTED

Committee on Education—Dr. Charles S. Higley, Cleveland, for a term of five years. Dr. Carl A. Wilzbach, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. John H. Budd, Cleveland, for a term of five years. Dr. E. J. Wenaas, Youngstown, a member of the committee, to serve as chairman for the ensuing year.

Committee on Public Relations and Economics—Dr. Herbert B. Wright, Cleveland, for a term of five years, and to serve as chairman for the ensuing year. Dr. Frank Mayfield, Cincinnati, to serve as a member of the committee for the years, 1953, 1954, 1955, 1956, inclusive, filling the unexpired term of Dr. George A. Woodhouse,

Pleasant Hill, who was elected Councilor of the Second District.

Committee on Scientific Work—Dr. Wm. F. Ashe, Gallipolis, for a term of five years. Dr. A. Carlton Ernstene, Cleveland, a member of the committee, to serve as chairman for the ensuing year.

On **motion** duly made, seconded and **carried**, the foregoing committee appointments were confirmed by the House of Delegates.

NEW BUSINESS

Under the order of new business Dr. Charles W. Pavey, delegate from Columbus, moved that the vote, by which Resolution F had been laid on the table, be reconsidered. Following a lengthy discussion a vote was taken and the **motion** to reconsider the vote, by which the resolution and the recommendation of the Reference Committee on it were laid on the table, was **defeated** by a vote of 33 to 34.

VOTE OF APPRECIATION

Dr. Ralph L. Rutledge, Alliance, was recognized and he moved that the House of Delegates extend sincere appreciation and thanks to the Committee on Scientific Work, Committee on Scientific and Educational Exhibits, all committees of the Cincinnati Academy of Medicine, members of the office staff of the Cincinnati Academy of Medicine, officials of the Netherland Plaza, Sheraton-Gibson and Sinton Hotels, and representatives of Cincinnati newspapers, radio and television stations, as well as to all program participants and others who had a part in making the Cincinnati meeting one of the best in the history of the Association.

Dr. Rutledge's **motion** was **adopted** by a standing vote.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary.

Narcotic License Must Be Renewed By July 1 to Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, reregister with the Director of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of $1.00. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

PENALTIES

Failure to reregister within the time allowed by law adds a penalty to the annual tax, and in addition makes the physician liable to a fine not exceeding $2,000 or to imprisonment for not more than five years or both. In recent years the Commissioner of Internal Revenue has given some tardy registrants the choice between paying sums by way of compromise in lieu of the penalties for their offenses, or as an alternative, accepting criminal prosecution, with resulting publicity and liability to fines and possible imprisonment. Strict adherence to the law will obviate the necessity for such action and protect the physician from needless embarrassment.

FORMS MAILED

Copies of Form 678, application for reregistration, are scheduled to be mailed about June 1 by the District Director of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed.

The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. In the case of a partnership, each partner must sign the application. **Remittance accompanying the application may be in the form of cash, a postal money order, or certified check. Personal checks not certified will be returned to senders.**

INVENTORY NECESSARY

Form 678 contains space on the reverse side for an inventory. The duplicate copy is to be retained by the registrant. Only the signature of the registrant is required on the form since it contains a declaration in lieu of a jurat.

Inventories may be taken at any time after the receipt of the application forms each year, and may be filed as soon as completed. They must be filed by July 1.

Physicians who administer, dispense, or prescribe cannabis, must obtain a special permit under the Marihuana Tax Act, and reregister annually on or before July 1, with the Director of Internal Revenue of his district, and pay a tax of $1.00 in addition to the regular registration fee.

MUST APPLY AFTER MILITARY SERVICE

A physician in the armed forces need not reregister. If such a physician should receive an application form for reregistration he should return it to the office of the Director of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

Upon his return to civilian practice, a physician who has been in military service must immediately apply for registration. He will be assigned his former registration number.

HOUSE OF DELEGATES
ROLL CALL—1953 MEETING

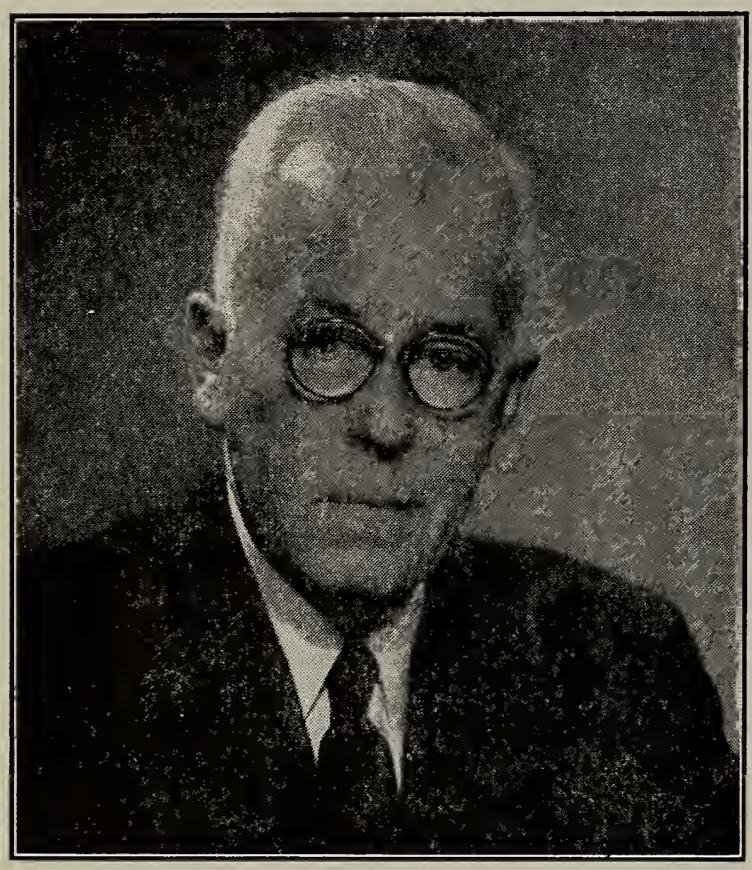
County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	S. J. Ellison	Present	Present
BROWN			
BUTLER	C. T. Atkinson	Present	Present
CLERMONT	A. A. Gruber	Present	Present
CLINTON	E. J. Yantes	Present	Present
HAMILTON	Richard D. Bryant	Present	Present
	Joseph G. Crotty	Present	----------
	J. W. Devanney, Jr.	----------	Present
	Edward C. Elsey	Present	Present
	John G. Fleming	Present	----------
	Harry L. Fry	Present	----------
	Harry K. Hines	----------	Present
	Joseph Lindner	Present	Present
	John H. Payne	Present	----------
	W. O. Ramey	Present	----------
	Robert C. Rothenberg	Present	Present
	Foster M. Williams	Present	Present
	Robert M. Woolford	----------	Present
HIGHLAND	John R. McBride	Present	----------
WARREN			
	SECOND DISTRICT		
CHAMPAIGN	I. Miller	Present	Present
CLARK	Martin J. Cook	Present	Present
	Ray M. Turner	Present	Present
DARKE	J. E. Gillette	Present	Present
GREENE	H. C. Messenger	Present	Present
MIAMI	G. A. Woodhouse	Present	Present
MONTGOMERY	Lynne E. Baker	Present	Present
	A. W. Carley	Present	Present
	R. C. Doan	Present	Present
	R. Dean Dooley	Present	Present
	T. L. Light	Present	----------
	W. H. Hanning	----------	Present
PREBLE	E. P. Trittschuh	Present	----------
SHELBY	H. Eugene Crimm	Present	----------
	G. J. Schroer	----------	Present
	THIRD DISTRICT		
ALLEN	Edward B. Young	Present	Present
AUGLAIZE	T. H. Will	Present	----------
CRAWFORD			
HANCOCK	Frank M. Wiseley	Present	Present
HARDIN	Floyd M. Elliott	Present	Present
LOGAN	Hobart L. Mikesell	Present	Present
MARION	Clovis J. Altmaier	Present	Present
MERCER	R. G. Schmidt	Present	Present
SENECA	R. F. Machamer	Present	Present
VAN WERT	Roland H. Good	Present	Present
WYANDOT	J. Craig Bowman	Present	Present
	FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	Present	Present
FULTON	C. S. Kellogg	Present	Present
HENRY			
LUCAS	Crawford L. Felker	Present	Present
	C. R. Forrester	Present	Present
	D. C. Frick	Present	Present
	W. W. Green	Present	Present
	G. H. Start	Present	Present
OTTAWA	Geo. A. Boon	Present	Present
PAULDING			
PUTNAM			
SANDUSKY	Richard R. Wilson	Present	----------
WILLIAMS	Paul G. Meckstroth	----------	Present
WOOD	Paul F. Orr	Present	Present
	FIFTH DISTRICT		
ASHTABULA	P. J. Collander	Present	----------
CUYAHOGA	F. L. Browning	Present	Present
	John H. Budd	Present	Present
	Joseph K. Doran	Present	----------
	H. A. Haller	Present	Present
	Carl A. Haman	Present	Present
	John B. Hazard	Present	Present
	C. R. Jablonoski	Present	Present
	Fred R. Kelly	Present	Present
	V. C. Laughlin	Present	----------
	E. A. Marshall	Present	Present
	Paul A. Mielcarek	Present	Present
	George W. Petznick	Present	Present
	J. M. Rossen	Present	----------
	H. W. Salter	----------	Present
	Keith W. Sheldon	Present	----------
	D. K. Spitler	Present	Present
	R. J. Whitacre	Present	----------
	Herbert B. Wright	Present	----------
GEAUGA	S. Hayashi	Present	Present
LAKE	Morris G. Carmody	Present	Present
	SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	Present	Present
MAHONING	Stephen W. Ondash	Present	Present
	Wm. M. Skipp	Present	Present
	Ivan C. Smith	Present	Present
PORTAGE			
STARK	Roy H. Clunk	Present	----------
	Lloyd L. Dowell	Present	Present
	R. L. Rutledge	Present	Present
SUMMIT	A. W. Friend	Present	Present
	Frank T. Moore	Present	
	Carl C. Nohe	Present	Present
	E. C. Pickard	Present	Present
TRUMBULL	E. R. Westbrook	Present	----------
	SEVENTH DISTRICT		
BELMONT	L. L. Liggett	Present	----------
CARROLL	Glenn C. Dowell	Present	Present
COSHOCTON	G. A. Foster	Present	Present
HARRISON	C. F. Goll	Present	Present
JEFFERSON	S. L. Burkhardt	Present	----------
MONROE			
TUSCARAWAS	H. E. Reed	Present	----------
	H. F. Van Epp	----------	Present
	EIGHTH DISTRICT		
ATHENS	L. I. Goldberg	Present	----------
FAIRFIELD	Leo E. Stenger	Present	Present
GUERNSEY	James A. L. Toland	Present	Present
LICKING	R. G. Plummer	Present	Present
MORGAN			
MUSKINGUM	A. C. Ormond	Present	Present
NOBLE			
PERRY			
WASHINGTON			
	NINTH DISTRICT		
GALLIA	Homer B. Thomas	Present	Present
HOCKING			
JACKSON			
LAWRENCE	George N. Spears	Present	Present
MEIGS	S. J. Blaszewicz	Present	----------
PIKE	R. M. Andre	Present	----------
	C. L. Critchfield	----------	Present
SCIOTO	O. D. Tatje	Present	----------
VINTON	H. D. Chamberlain	Present	Present
	TENTH DISTRICT		
DELAWARE	E. C. Jenkins	Present	Present
FAYETTE			
FRANKLIN	Wm. F. Bradley	Present	Present
	Joseph M. Gallen	Present	Present
	Geo. O. Kress	Present	Present
	James H. McCreary	Present	Present
	Chas. W. Pavey	Present	Present
	Henry H. Schwarzell	Present	----------
	C. C. Sherburne	Present	Present
KNOX	Henry T. Lapp	Present	Present
MADISON			
MORROW	Joseph P. Ingmire	Present	Present
PICKAWAY			
ROSS	Ralph W. Holmes	Present	Present
UNION	E. J. Marsh	Present	Present
	ELEVENTH DISTRICT		
ASHLAND	M. A. Shilling	Present	----------
ERIE	E. J. Meckstroth	Present	Present
HOLMES	N. P. Stauffer	Present	Present
HURON	C. J. Cranston	Present	Present
LORAIN	Theodore Berg	Present	Present
	John Halley	----------	Present
	Leonard Stack	Present	Present
MEDINA	H. T. Pease	Present	Present
RICHLAND	F. M. Wadsworth	Present	Present
WAYNE	Wm. R. Schultz	Present	Present
	OFFICERS		
President	H. M. Clodfelter	Present	Present
President-Elect	Paul A. Davis	Present	Present
Past-President	----------	----------	Present
Treasurer	R. L. Meiling	Present	Present
	COUNCILORS		
District			
First	D. W. Heusinkveld	Present	Present
Second	Merrill D. Prugh	Present	Present
Third	James R. Jarvis	Present	Present
Fourth	Carll S. Mundy	----------	----------
Fifth	Charles L. Hudson	----------	----------
Sixth	C. A. Gustafson	Present	Present
Seventh	R. J. Foster	Present	Present
Eighth	Robert S. Martin	Present	Present
Ninth	J. P. McAfee	Present	----------
Tenth	Wm. F. Mitchell	Present	----------
Eleventh	J. S. Hattery	Present	Present
	Totals	**130**	**108**

Presenting . . .

The New President-Elect and Four New Councilors of the Association Named by the House of Delegates at Annual Meeting in Cincinnati

THE House of Delegates elected a new President-Elect and four new Councilors at the Annual Meeting of the Ohio State Medical Association in Cincinnati, April 21-23. Following are biographical sketches of these new officers as well as information about other members of The Council.

Dr. Merrill D. Prugh, Dayton, was named President-Elect of the Ohio State Medical Association after serving four years as Councilor of the Second District. He will assume the Presidency at the 1954 Annual Meeting in Columbus.



MERRILL D. PRUGH, M.D.

A native of Preble County, Dr. Prugh received his preparatory schooling in the public schools and then attended Miami University, Oxford, where he received his A. B. degree. He received the Doctor of Medicine degree from Hahnemann Medical College in 1909, after which he took an internship at Genessee Valley Hospital, Rochester, N. Y. He did postgraduate work in surgery at the University of Edinburgh, Scotland, and at the London (England) Postgraduate School of Surgery.

In 1911 Dr. Prugh established his practice in Dayton and has practiced there continuously since, with the exception of time served during World War I with the Medical Corps overseas. He attained the rank of Captain and later was commissioned a Major in the Medical Reserve Corps.

For the first 25 years he practiced general medicine, but since 1936 has limited his field to general surgery. He is a member of the Dayton Surgical Society and a Fellow of the American College of Surgeons. Hospital affiliations include membership on the staff of Good Samaritan Hospital and the position as chief of the surgical staff at College Hill Hospital.

Dr. Prugh is a past-president of the Montgomery County Medical Society and served eight years as delegate of that society to the State Association. Also he served on local committees, and during World War II, was on the State Association's Procurement and Assignment Committee. He is a member of the American Medical Association.

In 1949, Dr. Prugh was honored by his Alma Mater by being named most outstanding alumnus of Miami University.

Dr. and Mrs. Prugh have two sons, Dr. Reed C. Prugh, who is associated in practice with his father, and Dan Prugh, in the manufacturing business in Dayton. Dr. Prugh's hobbies run to the out-of-doors variety, with hunting, fishing and skeet shooting predominating.

Following are biographical sketches of the incoming President and newly elected Councilors as well as information about other members of The Council.

INCOMING PRESIDENT

Dr. Paul A. Davis, Akron, was formally installed as President of the Ohio State Medical Association at the Cincinnati meeting. He was named President-Elect at the Cleveland meeting last year.



PAUL A. DAVIS, M. D.

A native of Chillicothe, Dr. Davis received his college training at Ohio State University and was awarded the M. D. degree from the College of Medicine in 1916. He took hospital training in Protestant and Children's Hospitals, Columbus, and later received residency training in industrial medicine, surgery and toxicology at Goodyear Hospital and the University of Chicago. Postgraduate work in industrial pathology was at the University of Chicago.

After serving as post surgeon and flight surgeon with the U. S. Army Air Force during World War I, Dr. Davis returned to the Goodyear Hospital in Akron where he was named industrial toxicologist and surgeon. He left the hospital as assistant medical director in 1940 and thereafter devoted full time to private practice. His practice includes that of industrial consultant in medicine and medical director for several companies.

Dr. Davis is past-president of the Summit County Medical Society and a former member of the Council of that organization. He also is a member of the Advisory Committee of the Summit County Tuberculosis and Health Association. He served six years as Councilor of the Sixth District before being named President-Elect.

Active in the organization of the American Academy of General Practice, Dr. Davis was elected its first President and subsequently served as chairman of its Board of Directors. He has served as chairman of the Section on General Practice of the A. M. A. and is the representative of that Section in the House of Delegates of the A. M. A. He also is the representative of the Section on Industrial and Preventive Medicine and Public Health to the A. M. A.'s Committee on Scientific Exhibits. In addition, he is a member of the A. M. A.'s Association of Section Delegates and a member of the A. M. A.'s Committee To Study the Problems of the General Practitioner. Other affiliations include fellowships in the American Association of Industrial Physicians and Surgeons and in the American Public Health Association and membership in the American Medical Historical Society.

He is active in several Masonic orders and holds memberships in a number of fraternal organizations. Mrs. Davis is a past-president of the Woman's Auxiliary to the Ohio State Medical Association.

SECOND DISTRICT COUNCILOR

Dr. George A. Woodhouse, Pleasant Hill, was elected Councilor of the Second District to succeed Dr. Prugh. Dr. Woodhouse comes to this office after an extensive and enviable record in medical organization work, extending from the county to the national level.



G. A. WOODHOUSE, M. D.

Born at Jacksonville, Athens County, in 1899, Dr. Woodhouse graduated from Jacksonville High School in 1917 and went into pre-medical training at Ohio University, Athens, where he received his A. B. degree in 1921. In 1924 he graduated from the University of Cincinnati College of Medicine.

He began his practice in Belmont County, but remained there only a short time before he moved to Pleasant Hill where he has been in general practice for the past 28 years.

Dr. Woodhouse got into medical organization work early in his career. For 25 years he has been secretary of the Miami County Medical Society and for the past 17 years has been delegate of that Society to the Ohio State Medical Association.

On the district level, he was president of the Second Councilor District Medical Society, 1936-1938 and its secretary from 1942 to 1949.

He has worked on one or more State Association committees continuously since 1938. In that year he was named a member of the Judicial and Professional Relations Committee and served until 1942. In 1940 he served on the Medical Service Plans Committee. He has served continuously on the Public Relations and Economics Committee for seven years, and has been on the Sub-Committee on Legislation since 1946 and its chairman since 1949.

He was first elected a delegate of the Ohio State Medical Association to the American Medical Association in 1942 and has served continuously since. He has served on several Reference Committees of the A. M. A. House of Delegates, and for the 1950 Clinical Session of the A. M. A. in Cleveland, he was chairman of the symposium on County Medical Society Public Relations.

The practice of Dr. Woodhouse includes memberships on the staff of Memorial Hospital,

Piqua, and the associate staff of Stouder Hospital, Troy.

Community activities include membership on the local Board of Education, the Pleasant Hill Board of Public Affairs of which he has been a member for 10 years and president for eight years. Other affiliations include memberships in the Congregational Christian Church, the American Legion (as a veteran of World War I) and various Masonic bodies including the Shrine.

Dr. Woodhouse was appointed to the Ohio Department of Health Hospital Advisory Council in 1947 and has been a member since.

Dr. Woodhouse is married and has four children. His daughter, Mrs. K. L. Jackson, is a Registered Nurse; George, Jr., will receive his M. D. degree from the University of Cincinnati College of Medicine this June; John is a graduate of Miami University, '51, and Dean is in the Army, serving at Camp Rucker, Ala.

FOURTH DISTRICT COUNCILOR

Dr. Paul F. Orr, Perrysburg, was elected Councilor of the Fourth Councilor District to succeed Dr. Carll S. Mundy, Toledo, who had served the maximum of three terms in that office.



PAUL F. ORR, M. D.

Dr. Orr was born September 5, 1898, at Holton, Kansas. His education was at Oklahoma A. and M. College, B. S. degree, 1915; Iowa State College, M. S. degree, 1918; and Harvard University Medical School, M. D. degree 1925.

After graduating from Oklahoma in 1915, he spent one year there as graduate assistant in chemistry and also in doing research work in bacteriology. The following year he was assistant bacteriologist in the Toledo Health Department. He resigned this position in 1917 to accept a research fellowship in the Department of Bacteriology, Iowa State College. After obtaining the M. S. degree there in 1918, he was appointed Charles Follen Folsom Teaching Fellow in the Department of Preventive Medicine and Hygiene, Harvard University Medical School. He held this appointment for three years under Dr. Milton J. Rosenau, teaching and doing research work on botulism. Dr. Orr matriculated in the Harvard Medical School in the fall of 1921, and during the following years as a medical student he was the recipient of the George Haven Scholarship, 1921-1922, the Joseph Eveleth Scholarship, 1922-1923, and while a fourth year medical student he was also assistant in the Department of Pathology. He was elected a member of Phi Kappa Phi and Alpha Omega Alpha honorary fraternities.

Dr. Orr served his internship at the Henry Ford Hospital, Detroit, during 1924-1925, following which he was appointed medical inspector and epidemiologist for the Michigan State Department of Health, which position he held for three years. In April, 1928, he was appointed commissioner of health for the City of Toledo. In October 1929 he opened an office for private practice of medicine in Perrysburg, where he has remained ever since, except for the years 1942-1946, when he was an officer in the U. S. Public Health service. During those years he was district health officer for an area of three counties adjacent to Fort Knox, Ky.

Since 1946, Dr. Orr has limited his medical practice to internal medicine. He is on the staffs of Toledo Hospital and Flower Hospital, Toledo. He has long been active in local and state medical work, having been delegate from Wood County to the Ohio State Medical Association continuously since 1939, except during the war years. He has served on various reference committees of the House of Delegates, including the Presidential Address, Credentials and Nominating Committees. He was elected president of the Wood County Medical Society for 1947 and reelected to the same position in 1948 and again in 1949. During the past three years, he has been chairman of the legislative Committee for the Wood County Medical Society. Since 1919 he has published numerous scientific articles in the fields of undulant fever, scarlet fever, botulism and typhoid fever.

Dr. Orr has been active in civic affairs, having been elected a member of the Board of Trustees of Public Affairs locally and named director of health for the Perrysburg Civil Defense program.

Dr. Orr is married and has one daughter. He is a member of the Methodist Church.

NINTH DISTRICT COUNCILOR

Dr. Carter L. Pitcher, Portsmouth, was elected Councilor of the Ninth District to succeed Dr. J. P. McAfee, Portsmouth, who resigned after serving five years on The Council.

Dr. Pitcher was born in the small town of Harrison on Coeur d'Alene Lake in northern Idaho. Shortly afterward the family moved to Moscow, Idaho, location of the University of Idaho, from which he received his B. S. degree in 1925. A year later he received his Master's degree and membership in the Society of Sigma Zi.

After one year at Leland Stanford University, he entered Northwestern University Medical School and graduated in 1931. This was followed by internship and surgical residency at Passavant Memorial Hospital in Chicago.

Dr. Pitcher opened his practice in Morral, in Marion County, and later moved to Marion where he practiced until 1938 with time out for postgraduate study at the Chicago Eye, Ear, Nose

and Throat Hospital and School. During 1937 he was secretary of the Marion Academy of Medicine.

He moved to Portsmouth in February 1938 and opened his office for practice, specializing in eye, ear, nose and throat work.

In August 1942 he went on active duty with the Army and was assigned as chief of the Eye, Ear, Nose and Throat Section of the 112th Station Hospital, which set up a 1,500-bed hospital in Calcutta, India, in June 1943. Illness forced his return to the States and in March 1945, he returned to his civilian practice in Portsmouth.



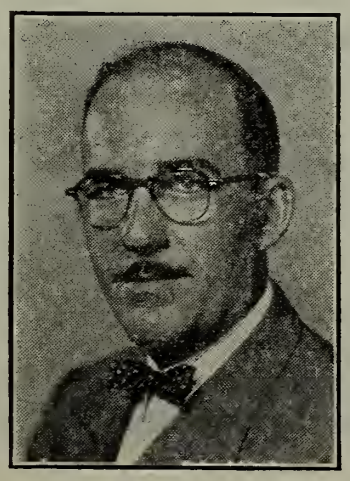
C. L. PITCHER, M. D.

He was elected chief of staff at Mercy Hospital in 1945 and has served in various capacities on the staff since; he also is on the staff of Portsmouth General Hospital. In the Scioto County Medical Society, he was elected secretary, 1949-1951, and president in 1952. On the State level, he has served as a member of the Military Advisory Committee since 1950.

In addition to his professional work, Dr. Pitcher is secretary of the Board of Trustees of the local Presbyterian Church and is a member of the Kiwanis Club and the Elks Lodge. Dr. Pitcher is married and has two sons, Carter Lee, Jr., a student at Ohio State University and Gerald D., attending the local high school.

TENTH DISTRICT COUNCILOR

Dr. Edwin H. Artman, Chillicothe, was elected Councilor of the Tenth District, to succeed Dr. William F. Mitchell, Columbus, who served two years on The Council and was not a candidate for reelection.



E. H. ARTMAN, M. D.

Dr. Artman was born in Portland, Indiana, but his family moved during his early childhood to Piqua where he was graduated from Piqua High School in 1928. His college work was at Ohio State University where he received his B. A. degree and later received his M. D. degree from the College of Medicine in 1935. Internship was at White Cross Hospital in Columbus.

Dr. Artman began his practice in Kingston, a town in northeastern Ross County. In 1941, he took courses in anesthesiology at the New York Postgraduate School and Hospital, and on returning to Ohio established his practice in Chillicothe, where he has been in general practice with special interest in anesthesia.

During World War II, he served four years in the U. S. Army Air Forces, Air Transport Command, serving first as a flight surgeon in the Arctic and later winding up his Army career as commanding officer of Morrison Field Hospital, West Palm Beach, Florida. While in the service, he attended the School of Tropical Medicine at the Army Medical Center, Washington, D. C., and the School of Malariology at Panama City, Panama, and the School of Aviation Medicine, Randolph Field, Texas.

Dr. Artman was chief of staff at Chillicothe Hospital in 1948 and 1949, and was president of the Ross County Academy of Medicine in 1950 and 1951. He was elected an alternate delegate to the American Medical Association for the years 1952 and 1953. Other affiliations include memberships in the American Society of Anesthesiology and the American Academy of General Practice.

He also is active in a number of civic and fraternal organizations; is director of health for the Ross County Civil Defense Program and a member of the Board of Directors of the Ross County Polio Foundation. He is first vice-president of the Chillicothe Chamber of Commerce and is affiliated with the Masonic Lodge, Elks' Lodge, Kiwanis Club and is a member of the official board of the local Methodist Church.

Dr. Artman is married and has two sons, Tom and Ned, both attending school in Chillicothe.

PAST-PRESIDENT

Dr. Harve M. Clodfelter, Columbus, as immediate Past-President of the Association, will continue to serve on The Council for another year.

TREASURER

Dr. Richard L. Meiling, Columbus, has served one year of a three-year term as Treasurer.

COUNCILORS REELECTED

Councilors reelected for additional two-year terms are:

Dr. Carl A. Gustafson, Youngstown, was reelected Councilor of the Sixth District. He was elected in 1952 to serve the remaining year of the unexpired term of Dr. Davis.

Dr. Robert Scott Martin, Zanesville, was reelected Councilor of the Eighth District. He was elected in 1952 to serve out the unexpired term of Dr. Chester P. Swett, who resigned.

Councilors in the midst of two-year terms are: Dr. David W. Heusinkveld, Cincinnati, First District; Dr. James R. Jarvis, Van Wert, Third District; Dr. Charles L. Hudson, Cleveland, Fifth District; Dr. R. J. Foster, New Philadelphia, Seventh District; and Dr. John R. Hattery, Mansfield, Eleventh District.

Annual Meeting in Review . . .

Excellent Attendance, Comprehensive Program, Business Sessions and Get-Togethers by Members All Add Up to Another Successful Meeting

ANOTHER successful program was spread on the records as the 1953 Annual Meeting, April 21-23, came to a close in Cincinnati. As indicated in the accompanying article on page 541, the attendance was excellent.

GUEST SPEAKERS

Thirteen out-of-state guest speakers added much to the diversified program—most of them speaking before both general sessions and specialty sections. In addition, many Ohio physicians took leading roles on the program.

Virtually all of the sessions were well attended, with the attendance at general sessions running as high as 350 or more persons.

THE COUNCIL AND HOUSE OF DELEGATES

The Council met twice in Cincinnati, the first time on Monday evening preceding the Annual Meeting, and the second time on Thursday following the meeting of the House of Delegates. The minutes of these meetings will be found on pages 519-520 of this issue.

The House of Delegates held its first meeting on Tuesday afternoon followed by an evening dinner in the Netherland Plaza Hotel. The second meeting was held following luncheon on Thursday, also in the Netherland Plaza. Minutes of these meetings, which establish policy of the Association, will be found beginning on page 521 of this issue.

Election of officers, a function of the House of Delegates, will be found in the official minutes, while biographical sketches of the new officers and other information on members of The Council will be found beginning on page 530.

SCIENTIFIC EXHIBITS

One of the main features of the Annual Meeting was the Scientific Exhibit on the Fourth Floor of the Netherland Plaza. Approximately 40 of these exhibits, graphically depicting various research projects, clinical studies and other educational features, were on display. The exhibits proved popular as they have at previous meetings, and at all hours of the day physicians could be seen brousing through and discussing various features with sponsors.

AWARD WINNERS

A committee designated by the President reviewed the exhibits and awarded first and second place winners. Signs were posted on the respective booths and certificates authorized for the place winners.

First Place went to the exhibit "Histoplasmosis in Man and Animals," sponsored by John A. Prior, M. D., Samuel Saslaw, M. D., Clarence R. Cole, D. V. M., and Deane Chamberlain, D. V. M., of the Departments of Medicine and of Veterinary Pathology, Ohio State University.

Second Place was awarded to the exhibit, "Revascularization Operations for Coronary Artery Disease," sponsored by Drs. Claude S. Beck and David S. Leighninger, Cleveland.

PUBLIC RELATIONS

When doctors get together, that's news, and the Annual Meeting proved no exception to the rule. Three top-ranking reporters were on hand to cover many phases of the meeting. They were Jerry Ransohoff of the *Cincinnati Post;* Helen Detzel of the *Cincinnati Times Star;* and James Golden of the *Cincinnati Enquirer.*

George H. Saville, director of public relations for the Association, and Hart Page, assistant director, kept constant liaison with the press. A press room was maintained by the Association in the Netherland Plaza Hotel for the convenience of reporters.

Periodically throughout the meeting as news developed releases were sent by special messenger service to newspapers, radio and TV stations and to the Associated Press and United Press wire services.

Literally hundreds of clippings have come into the Headquarters Office since the meeting to indicate that newspapers and other media throughout the state gave good coverage to the Annual Meeting.

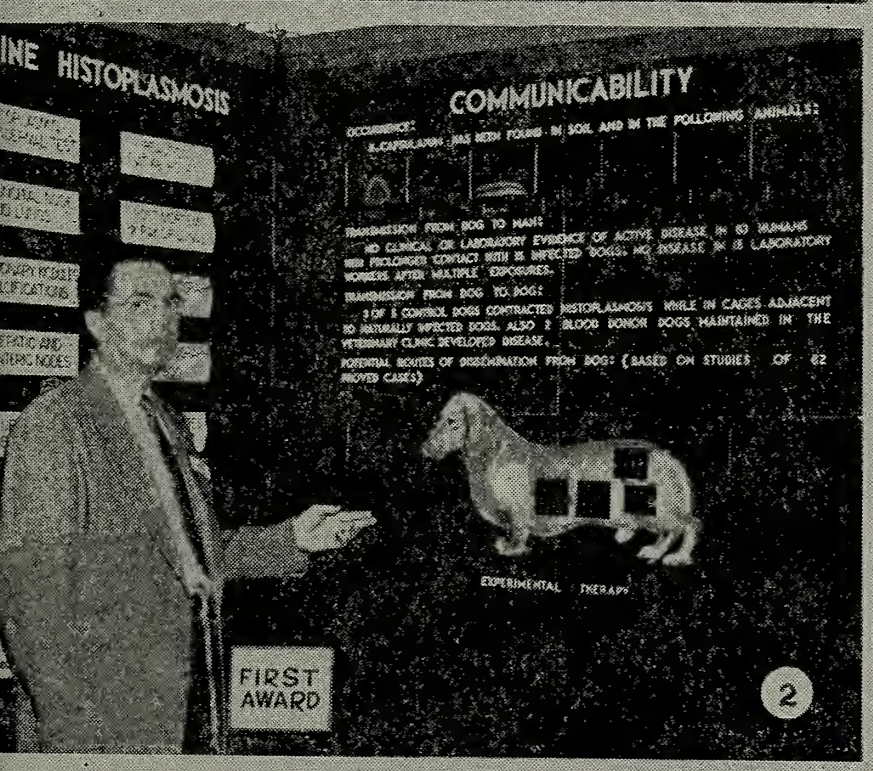
THE BANQUET

The beautiful Pavillon Caprice of the Netherland Plaza Hotel provided an appropriate setting for the Banquet and nearly 500 persons who attended. After the Officers, Councilors, distinguished guests and their ladies had made their entrance to the speakers' table, a sumptuous meal was enjoyed. Entertainment followed in the form of a floor show with several delightfully whimsical acts. An evening of dancing rounded out the social pause in the three-day program.

TECHNICAL EXHIBITS

Seventy-three outstanding supply houses were represented in the Technical Exhibit. Physicians made good use of the opportunity to talk with their detail men about the latest developments in the field of pharmaceuticals, dietary products, diagnostic and therapeutic equipment, books and many other products. Periods throughout the

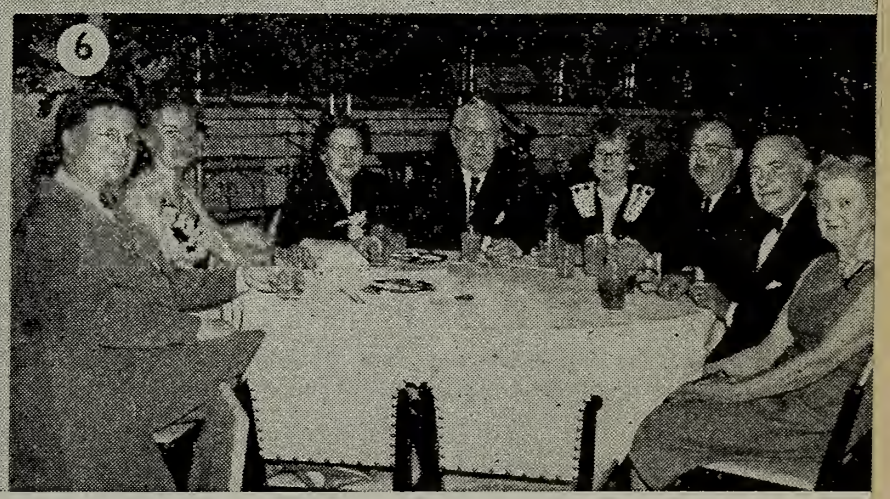












The camera caught this panorama of Annual Meeting high lights:

1. Members of the House of Delegates give their undivided attention.

2. Dr. John A. Prior, one of four sponsors, stands before the Scientific Exhibit which was awarded first place.

3. Discussing Association business are (left to right), Dr. Dooley, Dayton; Dr. Sherburne, Columbus; Mr. Thomas A. Hendricks, secretary of the A. M. A.'s Council on Medical Service; and Dr. Brindley, Toledo.

4. Incoming-President Paul A. Davis and Mrs. Davis.

5. Typical of the specialty section meetings was this session of the Section on Obstetrics and Gynecology.

6. A group from Tuscarawas County chat between dances following the Banquet.

program were allotted for the purpose of visiting the exhibits, because the Committee on Scientific Work felt that this was an integral part of the program.

PHONE SERVICE

Just to be sure that physicians didn't get too far away from their telephones during the Annual Meeting, the Academy of Medicine of Cincinnati operated a telephone call service. A booth was set up in the Netherland Plaza Hotel and was manned by the Academy as long as the program was in progress. Local personnel deserves a big thank you for providing this liaison service in the doctor-patient relationship.

SMOOTH RUNNING

Many members commented on the smooth running of the Annual Meeting and adherence to schedules. Two principal factors are involved in such an accomplishment—advance planning and



Exchanging greetings are (left to right) Incoming-President Paul A. Davis; Chairman of the Reception Committee, Lloyd E. Larrick; and Chairman of the Committee on Scientific Work, A. Carlton Ernstene.

"on-the-jobness" of local committees. Credit for this combination goes to the Committee on Scientific Work, headed by Dr. A. Carlton Ernstene, Cleveland; the Committee on Scientific and Educational Exhibits, with Dr. John F. Mueller as chairman; the Committee on General Arrangements, Dr. Lloyd E. Larrick, chairman; the Reception Committee, Dr. Charles W. Hoyt, chairman; and the Committee on Halls and Meeting Places, Dr. Warren L. Strohmenger, chairman.

PSYCHIATRIC SOCIETY ELECTS

New officers were elected at the annual meeting of the Ohio Psychiatric Association held at the Longview State Hospital, Cincinnati, April 20-21.

Dr. Joseph E. Duty, Toledo State Hospital, assumed office as president to succeed Dr. Douglas D. Bond, Cleveland.

Dr. Calvin M. Baker, Columbus, former state commissioner of mental hygiene, and now a private practitioner, was named president-elect.

Dr. Roger M. Gove, superintendent, Columbus State School, was elected secretary-treasurer to succeed Dr. Philip C. Rond, Columbus.

During the business session, the organization resolved to continue its efforts to establish in the profession a policy whereby psychiatrists who appear as expert witnesses before the courts, appear as "friends of the court" and not as witnesses for one side or the other.

The organization voted to hold conferences with representatives of the Blue Cross plans of the Columbus and Cleveland areas in an effort to have these plans cover hospitalized psychiatric patients on a basis comparable to coverage of medical and surgical patients.

OHIO SURGICAL SOCIETY FORMED

The Ohio Surgical Association was officially organized at a meeting of surgeons in Cincinnati on April 20, the day preceding the Annual Meeting of the Ohio State Medical Association.

The organization was conceived to offer to surgeons of Ohio an opportunity to meet one day each year, on the day preceding the Annual Meeting of the Ohio State Medical Association, the new officers reported.

These meetings will include scientific sessions and business meetings to discuss economic and political issues of interest to the particular group. It also will serve to better acquaint surgeons of the State with others in the same field.

At the organization meeting, a constitution, previously outlined by some thirty representatives from regional surgical societies and other surgical groups, was adopted and a president-elect chosen. The first year's slate of officers had previously been named by the representatives.

The present officers are: Dr. Clyde S. Roof, Cincinnati, president; Dr. Byron G. Shaffer, Toledo, president-elect; Dr. Tom F. Lewis, Columbus, secretary; and Dr. Berton M. Hogle, Troy, treasurer.

WOMAN'S AUXILIARY

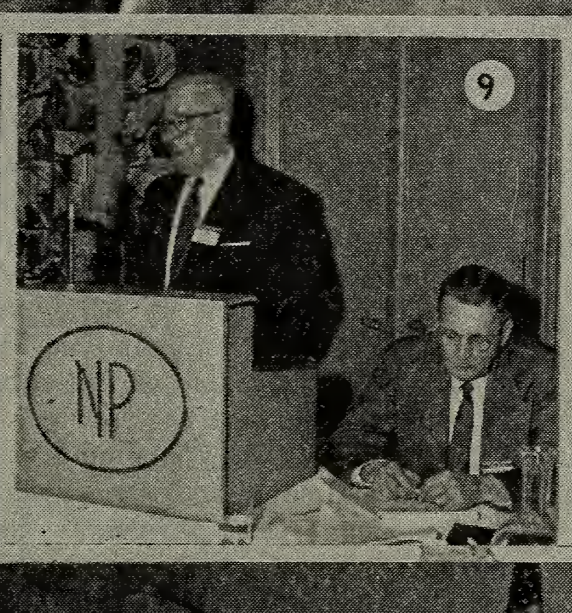
The Woman's Auxiliary to the Ohio State Medical Association held its Annual Meeting concurrently with the Association Annual Meeting.

Mrs. N. M. Reiff, Washington Court House, assumed office as president to succeed Mrs. Paul Woodward, of Cincinnati. The following officers were elected: Mrs. Paul Hancuff, Toledo, president-elect; Mrs. O. W. Jepson, Canal Winchester, vice-president; Mrs. O. Reed Jones, Cambridge, recording secretary; Mrs. James E. Rose, Washington C. H., corresponding secretary; and Mrs. Karl Ritter, Lima, treasurer.

Detailed report on the Auxiliary meeting will be published in an early issue of *The Journal.*

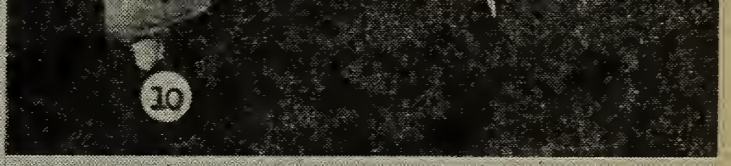




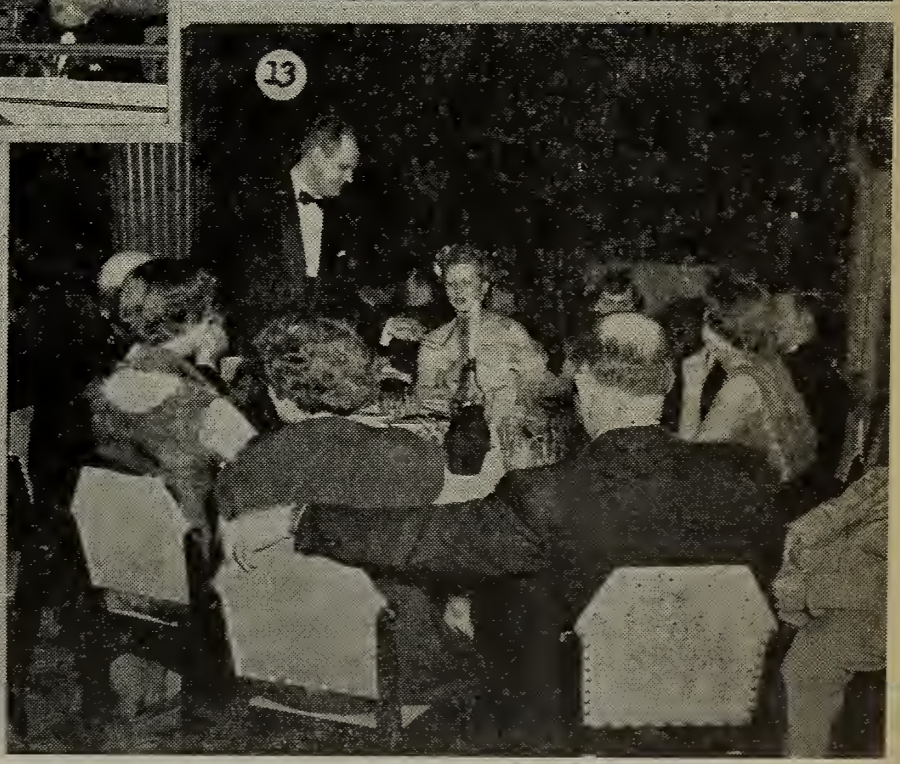












Additional Views snapped at the Annual Meeting:

7. The speaker's table at the Annual Banquet.

8. Dr. Costenbader, Washington, D. C., (left) and Dr. Reis, Chicago, two of the 13 out-of-state guest speakers.

9. Dr. Merrill D. Prugh, Dayton, accepts after being named President-Elect of the Association. Seated is Mr. Charles S. Nelson, Executive-Secretary.

10. Dr. Leighninger, Cleveland, (left) discusses specimens of the second-place Scientific Exhibit, "Revascularization Operations for Coronary Artery Disease," with Mr. Wolfe, Willoughby, a research assistant, and Mr. Law, Akron. Dr. Claude S. Beck and Dr. Leighninger sponsored the exhibit.

11. Dr. Dixon, Cleveland, (left, standing) presents outgoing-President H. M. Clodfelter, Columbus, with a gavel, symbol of his year in office.

12. An example of press relations: Helen Detzel, Cincinnati Times-Star, interviews Dr. Andrew S. Tomb, (center) a guest speaker, with the assistance of Dr. Herbert Chamberlain, McArthur.

13. Another group at the dance following the Banquet.

Address of the President . . .

Mechanism of State Association and Its Activities Outlined Before House of Delegates; Community Activity by All Physicians Emphasized

By H. M. CLODFELTER, M. D., Columbus, Ohio
(Presented to the House of Delegates, April 21, 1953, at Cincinnati)

ACCORDING to the agenda of this meeting, there is to be a presidential address. There are no rules or regulations which specify just what the President shall say. So, if you will bear with me, I should like to make a very informal report on just a few subjects which come to mind as I am about ready to turn to other hands the reins of the high office which I have had the honor and privilege of holding during the past year.

I should like to draw a comparison between what I am going to say and the driving of an automobile. There is a small rear view mirror. This enables the driver at times to look to the rear and see what has passed or what is coming from the rear. However, the driver must not use the mirror too often if he wants to get any place in safety.

The windshield on the auto is large, should be clean and the broader the view in front, the safer the driving will be.

MUST UNDERSTAND MACHINERY

It is likewise dangerous for one, even if he sees clearly through the windshield, when he does not understand well the machinery which controls the movements of his automobile.

So, to carry out the comparison, I want to take a glance into the rear view mirror of the Ohio State Medical Association; discuss in a general way the machinery which operates it; and offer a few suggestions as to how we can keep the windshield clean, in order that we can see ahead.

COUNTY SOCIETY THE KEYSTONE

Let's take a look at the mechanism of our State Association. The county medical society holds complete sovereignty. It has complete jurisdiction over accepting new members. It has the right to expel members for improper actions according to its own constitution and by-laws. Disciplinary actions should not be based on personal animosities but should be taken only for the good of the public, which, of course, means for the best interest of the medical profession, also.

This complete control of its membership is a high privilege for the county medical society. It is in accord with ideal democratic principles. However, in order for it to be good, it not only must be carefully guarded but also must be carried out as a mandate when circumstances warrant. The counties which are exercising this right and duty are to be commended. It is a tough job, but a highly essential one. This responsibility cannot be delegated to others. It is the duty of each county medical society and its members.

CIVIC ACTIVITY IMPERATIVE

The county medical society and its members are a part of the civic life of their community. Therefore, it is the duty of the society and its members to devote some of their time to community affairs and activities.

The greatest interest of course should be in things which have in some manner a bearing on the care of patients and on improving the health of the people of the community.

No medical activity of any kind should be carried on in any community without the approval and support of the physicians of the area. This means that physicians must find time to study proposals, make proposals and to carefully make recommendations which are best for the community. This takes time, but it is a duty. The people have a right to expect this kind of help and cooperation from members of the medical profession. If the physician is going to deserve and retain the high standing he holds in our social order, he must accept that great responsibility and deliver the goods to the fullest extent of his capabilities.

FUNCTION OF STATE SOCIETY

Obviously, certain problems arise which cannot be met by the county medical society. To meet these situations, we have formed a State Medical Association.

The governing body of that association is the House of Delegates—you, here in session today. The membership consists of delegates elected by the 88 county medical societies. Each society is entitled to one delegate for each 100 members or fraction thereof. Actually, you are a permissive body under the control of the 88 county societies.

At each annual session of the House of Delegates, certain questions are considered and certain basic policies laid down. At the same session, officers are elected.

RESPONSIBILITY OF THE COUNCIL

Since the House of Delegates meets regularly only once a year, it is impossible for it to pass

on all questions which may arise, especially new and unanticipated situations occurring during the ensuing months. For that reason, the Association has a Council—actually an executive body of the House of Delegates, but with the same powers as the House of Delegates during the period between Annual Meetings.

The state has been divided into 11 councilor districts. One councilor is elected by the House of Delegates as the representative of the councilor district in which he resides. The House of Delegates elects a treasurer who is a member of The Council. Also, it elects the President-elect who after one year becomes the presiding officer of the Association.

Thus, we have a Council of 15, all of whom are elected in a democratic manner, to carry on certain business of the Association in line with committee-type principles, between regular session of the House of Delegates. Of course, the House of Delegates may be called into special session at any time for good and proper reasons. It doesn't have to remain inactive until the next regular session. Usually, however, The Council can adequately handle any new business which may arise.

WELCOME SUGGESTIONS

At this point I should like to state that members of The Council welcome at all times suggestions and ideas from all county societies and from individual members. They are elected to serve the membership. They want to do a good job for you.

Also, I should like to pay tribute to past and present members of The Council. Constantly they are confronted with difficult and puzzling problems. They devote many hours and many days to the business of the Association. Because they have been willing to make these sacrifices and have exercised such good judgment on questions of real concern to all members, we have an Association of which we can be very proud.

THE COLUMBUS OFFICE

As long ago as 1913, the officials of the Ohio State Medical Association discovered that it was necessary for the Association to have a full-time executive office. We were the first medical society in the country to establish such an office. I should like to make a few comments regarding our present Columbus office.

Our full-time executive employees and members of their staff are the most capable, sincere, honest, hardworking and loyal persons ever employed by any organization anywhere. A large part of the success of the Ohio State Medical Association is due to that outstanding headquarters office force. I make this statement from firsthand knowledge. Can I say more?

However, in spite of the exceptional capabilities of our executive staff there are many functions which can only be performed by physicians—especially policy-making responsibilities.

PRAISES COMMITTEE WORKERS

The Association must have active committees and it does. Having met with most of them many times I have always been thrilled to see such highly capable men sacrifice their time and place all of their ability and energy into the work assigned to the committee on which they serve and try to work out the best possible solution to the tough problems under consideration. The untiring and unselfish work of these committees is one of the finest activities of organized medicine.

COMMITTEE WORK IMPORTANT

If I were to tell you something about the work of all of our committees, you would have to listen to me well into the evening. If I were to select only one or two committees for comment I would be unfair to other committees. Therefore, all I want to say is that all of us owe a debt of gratitude to the members of more than a dozen extremely active committees which have been serving you and me during the past year. They are the boards of review and fact-finding agencies for The Council. Without them and their help, The Council would be unable to carry on its work and meet its responsibilities to the membership.

In the Fall of 1951, Ex-President Harry S. Truman appointed a special commission to study the health needs of the nation. His views as to medical practice were a matter of record, as well as those of his appointee, Mr. Oscar Ewing. This commission was told to hold hearings in order to gain firsthand information.

PRESENTED MEDICINE'S VIEWS

About the middle of last August we learned that a hearing was to be held in Cleveland on September twenty-first. A letter was written to the Commission advising it that we would be willing to place our resources and information concerning medical and health matters in the State of Ohio at its disposal. Our diligent office force went to work to gather the material in the most suitable form in case the Commission wanted it.

We received a letter from that body about ten days before the hearing, stating that we would be given ten minutes to make a presentation before the Commission but that we could file all of the material we so selected with it for study.

At the hearing which I attended on authorization of The Council, it was most interesting to hear some groups somewhat antagonistic to medicine present the statements as to the inadequacies of medical and health conditions in Ohio and to infer that organized medicine had given little attention to them. Along about two in the afternoon I had the honor to present our ten

minutes worth of testimony. It must have been quite a shock to some of the so-called opponents of organized medicine. You may remember that back in 1946 the Ohio State Medical Association developed a 25 point program which enumerated the problems in relation to medicine and health in our State and set forth a positive and definite program to meet them. My presentation merely enumerated what the problems were, what we had been doing about them and what we were going to try to do in the future.

O. S. M. A. PROGRAM CONSTRUCTIVE

It was a most pleasing circumstance for me to be able to speak for a profession which had already recognized the problems in our State, and a profession which had already been doing something about those problems. It was obvious that our interest had not been a panic-stricken effort to cope with any challenge which had been established by appointment of the Truman Commission. At the close of my presentation I presented the Commission with a large portfolio of documentary evidence supporting what I had been able to present only sketchily in the ten minutes allotted. It was a particular pleasure to be the one to represent our profession which through our Association had done such a good job long before the Truman Commission came into existence.

A LOOK AT THE FUTURE

I hope the county societies will continue to do a good job—an even better one in the future. I hope the State Medical Association can continue its progressive program and improve upon it in the future.

Now comes the time when I shall begin looking through the windshield into the future.

Ohio is no longer a wilderness on the banks of the Ohio River. It is an integral part of our Nation. Our interests are rapidly expanding to the entire nation. We can't even stop there. Radio waves have changed the lives of this world. If this talk were being broadcast by radio and television, a native of South Africa sitting within six feet of his radio would hear my words before any of you in this room would hear them. With jet and rocket propulsion that same South African is only a matter of a few hours—NOT days—away from us. These world influences are moving in on Ohio thousands of times more rapidly than the covered wagons of less than a century ago. We cannot ignore these developments.

THE PROFESSION AND WORLD PEACE

The atomic age is forcing us to seek a universal peace. If we do not achieve peace, for the first time in history we have the means to destroy the entire world. Atomic energy can either revolutionize civilization for good or it can destroy the world. We as physicians hold one of the important keys in helping to obtain that universal peace.

The little mother in Bombay will hear over the radio that the mothers in America are able to bring all of their children through the trials of childhood safely. That little Indian mother wants to bring her children up safely too, not have them die as babies and children. We must help them to prevent their children from dying. The little Chinese mother sees her children starving to death and she hears of the healthy American children who drink two quarts of pasteurized, homogenized, standardized and fortified milk per day. She wants that milk for her children. That is economic. Medicine is a part of that economy. We must do our part. The members of a family whom we may have helped to bring up into adulthood as healthy, happy, active, productive persons are not so likely to be subject to subversive activity.

The world has made scientific progress far beyond the imagination of only a few years ago. Medicine has been in the forefront of that advance. I do not wish to claim credit for the advances in medical science for physicians alone since we have had tremendous help from other branches of science and from the co-operative patients, but nevertheless great impetus has been given by our profession over the years.

WHAT DOCTOR OF FUTURE MUST BE

With this marvelous advance it becomes more and more important who is to become the physician of tomorrow. I firmly believe that certain basic attributes should be sought in applicants for medical training in the following order: The first and by far the most important attribute which the physician of the future must have is good CHARACTER. Without that the people are not safe. The second most important attribute is MOTIVATION. A man with good character and a high motivation will never harm the patient. The third is ABILITY. We need it, but without the first two it can be dangerous. Character, motivation and ability, all of them of the highest order, will maintain the standards of medical care and cause it to reach heights far beyond even our wildest imagination. Medicine must have the share of the best.

We have a responsibility of the highest order. We can lead in the development of world understanding and universal peace. As the parable of the Talents of Silver implies, we must not hoard or bury our talents but must make them produce to the fullest extent. We have the greatest opportunity of any group in the history of the world to place service to mankind above the dollar sign.

In short, it is our duty to protect the people of the world against the bad and to GUARANTEE them the good in medicine.

Annual Meeting Attendance . . .

Total of 2,435 Persons Registered at Cincinnati Meet, April 21-23; Attendance by Counties Is Given with Roster of Members Present

AN excellent attendance was recorded at the 1953 Annual Meeting of the Association in Cincinnati, April 21-23, with a total of 2,435 persons. Following is the break-down of this total: Members, 1,115; out-of-state physicians, 33; interns, residents and Ohio guest physicians, 147; medical students, 224; scientific and technical exhibitors, 298; Woman's Auxiliary, 358; miscellaneous guests, 220.

Following are registration figures by counties, comparison of attendance at Annual Meetings from 1919 through 1953, followed by a roster of members present:

REGISTRATION, 1953 ANNUAL MEETING BY COUNTIES AND MEMBERSHIP DATA

County	Total Membership Dec. 31, 1952	Total Membership April 17, 1953	Annual Meeting Registration
Adams	10	9	3
Allen	93	85	12
Ashland	24	22	3
Ashtabula	46	49	4
Athens	30	28	3
Auglaize	18	17	5
Belmont	48	47	1
Brown	12	11	6
Butler	129	134	34
Carroll	10	10	2
Champaign	18	18	4
Clark	110	105	25
Clermont	28	31	15
Clinton	22	22	14
Columbiana	68	66	7
Coshocton	24	18	1
Crawford	29	23	4
Cuyahoga	1,743	1,599	67
Darke	23	22	6
Defiance	16	15	2
Delaware	23	23	6
Erie	54	55	4
Fairfield	43	38	7
Fayette	12	12	5
Franklin	710	676	113
Fulton	18	22	2
Gallia	26	25	5
Geauga	11	11	1
Greene	36	38	7
Guernsey	29	29	4
Hamilton	1,038	1,013	364
Hancock	36	33	5
Hardin	25	25	6
Harrison	11	11	2
Henry	11	9	—
Highland	19	18	9
Hocking	11	10	2
Holmes	9	9	3
Huron	23	22	3
Jackson	14	15	2
Jefferson	52	44	4
Knox	30	28	5
Lake	41	36	3
Lawrence	19	19	7
Licking	54	54	8
Logan	25	24	2
Lorain	140	128	7
Lucas	479	441	35
Madison	10	10	—
Mahoning	248	230	20
Marion	54	47	6
Medina	25	24	5
Meigs	10	7	3
Mercer	19	18	5
Miami	43	48	15
Monroe	4	4	—
Montgomery	409	406	90
Morgan	6	5	—
Morrow	8	8	3
Muskingum	52	48	6
Noble	3	3	—
Ottawa	18	14	2
Paulding	11	11	—
Perry	13	13	1
Pickaway	18	16	2
Pike	10	9	3
Portage	28	27	1
Preble	12	12	2
Putnam	12	13	2
Richland	97	98	17
Ross	43	38	11
Sandusky	34	37	2
Scioto	64	61	19
Seneca	41	39	7
Shelby	17	16	4
Stark	268	258	28
Summit	373	371	17
Trumbull	100	96	5
Tuscarawas	50	48	9
Union	19	20	4
Van Wert	17	19	3
Vinton	3	2	1
Warren	12	14	4
Washington	28	18	2
Wayne	56	52	5
Williams	18	13	3
Wood	39	36	6
Wyandot	14	12	3
Totals	7,806	7,420	1,155

ANNUAL MEETING REGISTRATION FOR 1919-1953, INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1813
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with A. M. A.						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			441	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435

Members of State Association Registered at 1953 Meeting

Adams County—Samuel J. Ellison, Robert L. Lawwill, Hazel L. Sproull.

Allen County—Dwight L. Becker, R. D. Doughty, F. Miles Flickinger, G. E. Jones, Walter A. Noble, Franklin D. Rodabaugh, Ralph R. Snowball, Roger L. Tecklenberg, Herbert A. Thomas, John F. Tillotson, Edward B. Young, Carl H. Zinsmeister.

Ashland County—C. F. Gibbons, Paul E. Kellogg, Myron A. Shilling.

Ashtabula County—Walter J. Brown, Shepard A. Burroughs, Paul J. Collander, Donald D. Forward.

Athens County—Lawrence I. Goldberg, Julien M. Goodman, Charles R. Hoskins.

Auglaize County—William V. Barton, Clyde W. Berry, David W. Nielson, Richard H. Schaefers, T. H. Will.

Belmont County—Lewis L. Liggett.

Brown County—Donald L. Domer, John R. Donohoo, Lyle C. Franz, Vytautas Karoblis, Charles H. Maly, Ralph F. Wilkins.

Butler County—C. T. Atkinson, Hugh J. Baker, John L. Bauer, Donald M. Blizzard, Harry L. Burdsall, J. A. Carter, Clyde G. Chamberlin, Felix Gustav Cohn, Malcolm O. Cook, Mabel E. Gardner, Jack L. Harris, William H. Henry, Kenneth E. Higgins, Ross A. Hill, Willis Fulton Hume, Vera Coombs Iber, Kurt E. Lande, Henry A. Long, William U. Neel, William I. Owens, Glendon E. Parry, Bernard H. Roberts, Vernon E. Roden, Walter H. Roehll, John D. Schonwald, Paul C. Schumacher, John Edward Singer, G. Calvin Skinner, Mildred Law Snyder, Clyde I. Stafford, E. T. Storer, William E. Storer, Harry N. Ward, Robert M. Wilson.

Carroll County—Glen C. Dowell, Carl A. Lincke.

Champaign County—V. R. Frederick, Forrest E. Lowry, I. Miller, John R. Polsley.

Clark County—Frank W. Anzinger, Edwin E. Ash, John E. Burnett, Jr., N. L. Burrell, Martin J. Cook, Wm. H. Crays, Carl T. Doeing, Harold Fishbain, Samuel K. Gerson, James G. Gianakopoulos, William J. Habeeb, Thomas M. Hayes, Wesley E. Knaup, Francis C. Link, Robert A. McLemore, William H. Miller, George F. Parker, Delbert J. Parsons, Nicholos B. Pavlatos, Lillian M. Posch, Carl H. Reuter, Geneva L. Shong-Rothemund, J. H. Shanklin, Ray M. Turner, S. C. Yinger.

Clermont County—C. F. Barber, Harry M. Breuer, J. M. Coleman, John T. Crone, Walter A. Culley, Owen C. Davison, Adolph A. Gruber, Mary L. Hippert, Carl A. Minning, Evelyn R. Pauly, Allan B. Rapp, Geo. E. Rockwell, Chas. M. Simmons, F. S. Skeen, Warren E. Thomas.

Clinton County—H. Richard Bath, Richard R. Buchanan, Robert Conard, J. H. Frame, Roy D. Goodwin, Kelley Hale, Nathan S. Hale, Maxine K. Hamilton, V. E. Hutchens, Arthur F. Lippert, Robert E. Suer, Ralph H. Vance, William L. Wead, Edmond K. Yantes.

Columbiana County—Wade A. Bacon, William S. Banfield, Paul W. Conrad, John A. Fraser, Raymond T. Holzbach, James R. Moorehead, William F. Stevenson.

Coshocton County—Gerald A. Foster.

Crawford County—Edward C. Brandt, John M. Kidd, Theodore D. Sawyer, Robert L. Solt.

Cuyahoga County—Stacey A. Besst, William F. Boukalik, Francis L. Browning, John H. Budd, Everette Peter Coppedge, Jr., Joseph A. Crowley, Paul S. Curran, Harold C. Curtis, Hamilton S. Davis, Stanley N. P. DeVille, Fred W. Dixon, Joseph K. Doran, Carroll C. Dundon, Donald B. Effler, Eduard Eichner, I. H. Einsel, Thos. H. Einsel, Irene S. Endrey, William J. Engel, A. Carlton Ernstene, F. Graham Fallon, Harold Feil, Farrell T. Gallagher, Francis J. Gannon, Jerome A. Gans, Frank P. Geraci, Michael C. Geraci, Donald M. Glover, Donald E. Hale, Harry A. Haller, Carl A. Hamann, James R. Hart, Robert B. Hauver, John B. Hazard, C. R. Jablonski, Albert L. Jones.

Oliver Kechele, Fred R. Kelly, Roscoe J. Kennedy, E. F. Kieger, Max L. Kirk, Henry E. Kretchmer, Michael J. Krisko, Vincent T. LaMaida, Victor C. Laughlin, Martin M. Mandel, Edward A. Marshall, Robert J. McCaffery, Paul A. Mielcarek, Paul M. Moore, George W. Petznick, Harry D. Piercy, Joseph McK. Rossen, Herbert W. Salter, Brant Burdell Sankey, Keith W. Sheldon, David K. Spitler, L. J. Sternicki, Harry M. Strachan, Paul J. Steuber, Harold R. Swan, Samuel L. Vinci, Louis A. Vogel, H. C. Weinberg, R. J. Whitacre, Herbert B. Wright, Burdette Wylie.

Darke County—Emmett W. Arnold, Edward Westbrook Browne, John E. Gillette, Marion Wm. Johnson, Maurice M. Kane, Gilbert E. Sayle.

Defiance County—John D. Cameron, Dyle J. Slosser.

Delaware County—William E. Borden, Don L. Gantt, Edward C. Jenkins, Douglas L. Smith, F. M. Stratton, Chester B. Theiss, Jr.

Erie County—David Richard Lehrer, Henry William Lehrer, Emil J. Meckstroth, Joseph P. Ohlmacher.

Fairfield County—Robert S. Bode, William S. Jasper, A. M. Kelley, Elson D. McCullough, Leo E. Stenger, Chester P. Swett, Kenneth W. Taylor.

Fayette County—J. H. Persinger, Newton M. Reiff, James E. Rose, Marvin H. Roszmann, Byers S. Shaw.

Franklin County—Louise P. Ainsworth, Marion L. Ainsworth, J. J. Alpers, James M. Andrew, Neil C. Andrews, Drew J. Arnold, Charles R. Baber, Earl H. Baxter, Ralph E. Blackford, R. W. Bonnell, Wm. F. Bradley, John E. Brown, Jr., Robert H. Browning, Olan P. Burt, Alice M. Bustin, Antonio V. Camera, Lewis W. Cellio, H. William Clatworthy, Jr., Harve M. Clodfelter, Oscar L. Coddington, George F. Collins, Constance J. Connors, John N. Cross, Thomas R. Curran,

Dwight H. Davies, C. J. Delor, Hugh C. Dorr, Joseph M. Dunn, A. D. Echert, Sam D. Edelman, Karl H. Feistkorn, Frederick C. Finke, Joseph C. Forrester, Frank C. Frailie, John S. Fung, Clarence M. Gallagher, Francis T. Gallen, Joseph M. Gallen, John P. Garvin, Paul E. Grimm, Walter H. Hamilton, George T. Harding, Harold K. Harris, Margot D. Hartmann, Charles H. Hendricks, James L. Henry, R. Jean Henry, David K. Heydinger, Willis H. Hodges, Julius Hoffman, Oliver W. Hosterman, Jacob J. Jacoby, Louis N. Jentgen, Oscar W. Jepsen, Charles E. Johnston,

Henry W. Karrer, Addison L. Kefauver, Paul Kirch, Karl P. Klassen, Edward G. Klopfer, Albert Kostoff, George O. Kress, E. C. Lawless, Paul W. Leithart, Florence Lenahan, Norris E. Lenahan, D. R. Lewis, Sydney N. Lord, John M. Lowery, Robert H. Magnuson, Louis Mark, George T. Mathews, Charles W. Matthews, James H. McCreary, Charles W. McGavran, II, John W. Means, Richard L. Meiling, Jack W. Miles, William J. Miller, William F. Mitchell, Jos. L. Morton, Robert J. Murphy, Wm. G. Myers, Dwight M. Palmer,

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Geauga County—Shigeki Hayashi.

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Josef D. Weintraub, Andrew J. Weiss, Ashton L. Welsh, Carl H. Wendel, Elmer Werner, Wm. Wertheim, Daniel A. Whalen, Russell F. Wiggers, Walter B. Wildman, II, Foster M. Williams, Joseph N. Wilson, Merton Wilson, Carl A. Wilzbach, Glenn L. Winkle, Sydney Wolfgang, Robert W. Woliung, Edward Woliver, Ling G. Wong, Robert M. Woolford, Joseph F. Wright, Makoto Yamaguchi, Lloyd F. Zacharias, Jerome Zeigler, Albert R. Zoss.

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Harrison County—Carl F. Goll, G. E. Henderson.

Highland County—John G. Anderson, J. Martin Byers, Robert G. Claeys, Walter Felson, Clifford G. Foor, W. M. Hoyt, H. H. Lowe, William C. Martindill, John R. McBride.

Hocking County—Richard C. Jones, H. G. Southard.

Holmes County—Adam J. Earney, Owen F. Patterson, Neven P. Stauffer.

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Knox County—Joseph W. Allman, Henry T. Lapp, James C. McLarnan, Gordon H. Pumphrey, Julius Shamansky.

Lake County—Morris G. Carmody, Richard W. McBurney, Rickard S. Toomey.

Lawrence County—Anne Marting-Alstott, John A. Dole, Jr., William F. Marting, Thomas E. Miller, Harry Menni, George N. Spears, Wm. Ray Swango.

Licking County—W. Allen Avery, Andrew S. Burton, George A. Gressle, Willard E. House, James B. Johnson, James Kenneth Nealon, Arnold D. Piatt, Raymond G. Plummer.

Logan County—Hobart L. Miksell, John B. Traul.

Lorain County—Theodore Berg, Charles J. Cooley, Romeo A. DeMarco, John Halley, Georgia Scharff, Leonard A. Stack, John L. Sullivan.

Lucas County—Paul L. Bell, Charles A. Bohnengel, Arthur A. Brindley, Porter B. Brockway, John F. Buck, Joseph E. Duty, Crawford L. Felker, Charles R. Forrester, David C. Frick, John Gardiner, E. Benj. Gillette, Warren Wendell Green, Elmer Haynes, John F. Hillabrand, Bernard A. Karwowski, Gilbert D. Keil, Jean B. Koupal, Rollin W. Kuebbeler, Adelbert J. Kuehn, George H. Lemon, Maurice R. McGarvey, Clarence W. McNamara, Myron G. Means, Harry F. Mignerey, Joseph P. Moran, Robert W. Muenzer, Foster Myers, Edward F. Ockuly, Frederick P. Osgood, Joseph A. Radecki, Maurice A. Schnitker, Byron G. Shaffer, G. H. Start, W. C. Suter, Earl F. Ward.

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Marion County—Clovis J. Altmaier, Robert T. Gray, James S. Greetham, Benjamin D. Osborn, E. T. Sager, Warren C. Sawyer.

Medina County—Otis G. Austin, C. J. Ferber, Horatio T. Pease, Frank C. Reutter, Morris Wilderom.

Meigs County—Selim J. Blazewicz, Raymond E. Boice, Roger P. Daniels.

Mercer County—Chas. P. Adkins, Paul E. Beare, John W. Chrispin, James J. Otis, Rudolph G. Schmidt.

Miami County—William N. Adkins, Paul E. Foy, George J. Hance, Frank R. Hanzel, Berton M. Hogle, Dale A. Hudson, Maynard C. Kiser, Kenneth F. Lowry, Ernest T. Pearson, E. C. Puterbaugh, Wm. W. Trostel, W. W. Weis, John M. Wilkins, George A. Woodhouse, Ralph D. Yates.

Montgomery County—Roy D. Arn, Vincent A. Aufderheide, Robert C. Austin, Wm. B. Ayres, Lynne E. Baker, Raymond K. Bartholomew, Herman J. Bearzy, Edward V. Bennett, David L. Bernie, Roy S. Binkley, Morton E. Block, Austin T. Brogan, Russell N. Brown, Robert A. Bruce, Herbert L. Brumbaugh, Henry J. Caes, Arthur W. Carley, A. J. Carlson, Homer D. Cassel, Darrell C. Caudill, Everett F. Conlogue, Lloyd H. Cox, James P. Curran, Conrad DeBold, Sydney H. Dinkin, Roscius C. Doan, R. Dean Dooley, John M. Duchak, Clarence L. Fraas,

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Jack M. Randall, Cecil F. Rust, Louis Ryterband, Richard T. Sauer, Harry B. Schiffer, Everett W. Shank, Paul J. Shank, Ned D. Shepard, Corwin A. Smith, C. Sidney Smith, E. Wallace Smith, Harvey J. Staton, Leon Stein, W. V. Stinson, Henry L. Strohmeyer, Jerome S. Surdyk, W. B. Taggart, Edward R. Thomas, Nicholas J. Thompson, John F. Torrence, Allan L. Wasserman, Joseph M. Wilson, Giles Wolverton, John R. Woodruff, Orrville M. Wright, Paul L. Yordy, Robert E. Zipf.

Morrow County—Wm. S. Deffinger, Joseph P. Ingmire, W. Lowell Murphy.

Muskingum County—W. L. Cruise, Walter B. Devine, Benjamin W. Gilliotte, Robert S. Martin, Alfred C. Ormond, George T. Thompson.

Ottawa County—Geo. A. Boon, William H. Dufendock.

Perry County—Olen D. Ball.

Pickaway County—Marion D. Gamble, Vemont D. Kerns.

Pike County—Robert M. Andre, Geo. W. Cooper, C. L. Critchfield.

Portage County—Edward T. Meacham.

Preble County—C. J. Brian, Everett Paul Trittschuh.

Putnam County—Joseph J. McHugh, Harry A. Neiswander.

Richland County—Paul A. Blackstone, C. O. Butner, Rundle D. Campbell, Carl R. Damron, Edward D. Dowds, Joseph B. Edelstein, Robert L. Garber, Charles L. Hannum, John S. Hattery, Charles R. Keller, Wm. R. Roasberry, Robert P. Scott, Joseph E. Seibert, Charles L. Shafer, J. L. Stevens, Albert H. Voegele, F. M. Wadsworth.

Ross County—Harold Crumley, Theo. Cutright, Ralph W. Holmes, Charles N. Hoyt, A. E. Merkle, Francis Wayne Nusbaum, M. Dow Scholl, Byron Stinson, William A. Stoll, Joseph Utrata, Adolf Wolff.

Sandusky County—Anthony C. Rini, Richard R. Wilson.

Scioto County—Dow Allard, Walter A. Braunlin, J. Walter Daehler, Clyde M. Fitch, William C. Hugenberg, A. P. Hunt, Carl H. Laestar, Milton Levine, Ralph W. Lewis, James P. McAfee, Armin A. Melior, Oscar Micklethwait, Gilbert Micklethwaite, Garnett E. Neff, Carter L. Pitcher, Henry F. Rogowski, Marie B. Rogowski, Oral D. Tatje, Philip D. Weems.

Seneca County—Henry L. Abbott, John C. Bauer, Walter A. Daniel, Wm. R. Funderburg, E. F. Ley, R. F. Machamer, Robert E. Schriner.

Shelby County—R. W. Alvis, H. Eugene Crimm, George J. Schroer, William A. Schroer.

Stark County—Laurence E. Anderson, Arden Ray Basinger, Hiram J. Bazzoli, Bernard R. Bonnot, Aubrey E. Boyles, Joseph J. Brumbaugh, Roy H. Clunk, Lloyd L. Dowell, James R. Dowling, Delmar R. Gard, Harry W. Gauchat, Floyd C. Hendrickson, Mark G. Herbst, E. Scott Hill, John D. Joliet, Richard H. Kelty, Douglass S. King, George L. King, Esther E. Kojinsky, James A. McNalley, Otto L. Plaut, Ralph K. Ramsayer, Ralph L. Rutledge, Clarence V. Smith, Paul E. Smith, Robert E. Tschantz, Louis L. Weiss, George M. Wilcoxon.

Summit County—Millard C. Beyer, Paul A. Davis, Philip B. DeMaine, Reynold Paul Desman, A. William Friend, Edward F. Hellwig, Harold H. Klingler, Armond L. Leiby, Donald E. Leonard, Frank T. Moore, Carl C. Nohe, Thayer L. Parry, Edgar C. Pickard, J. Paul Sauvageot, Hazel P. Simms, Donald M. Traul, Frank M. Warner.

Trumbull County—E. G. Caskey, Francis T. Kandrac, Joseph A. Ralston, Louis G. Ralston, Edwin R. Westbrook.

Tuscarawas County—David H. Allen, Philip T. Doughten, Morrison W. Everhard, Ruel J. Foster, Paul D. Hahn, Horace E. Reed, Herbert F. Van Epps, Harold F. Wherley, F. C. Yeager.

Union County—Fred Callaway, Charles W. Holcomb, Everet J. Marsh, Harold E. Stricker.

Van Wert County—Gwilym A. Edwards, Roland H. Good, James R. Jarvis.

Vinton County—H. D. Chamberlain.

Warren County—James H. Arnold, Arch D. Harvey, O. Willard Hoffman, Orville L. Layman.

Washington County—Ford E. Eddy, Myer S. Muskat.

Wayne County—Robert A. Anderson, H. Hays Bullard, Ford C. Ganyard, Richard W. Reiman, William R. Schultz.

Williams County—Robert J. Bemis, Paul G. Meckstroth, J. R. Riesen.

Wood County—Henry W. Dierksheide, Donald L. Gamble, Paul F. Orr, Roger A. Peatee, Frederick F. Price, Wm. S. Rothe.

Wyandot County—J. Craig Bowman, Raymond J. Murphy, Franklin M. Smith.

Do You Know? . . .

Two Ohio physicians were elected directors, 1953-1955, of the Industrial Medical Association in Convention at Los Angeles, April 20-24. They are Dr. Charles F. Shook, medical director of the Owens-Illinois Glass Company, Toledo; and Dr. H. W. Lawrence, medical director of the Procter & Gamble Company, Cincinnati.

* * *

Dr. Jonathan Forman, Editor of *The Journal*, spent three days in Washington, D. C., in mid-April as a member of the Sponsor's Council set up by Resources for the Future, Inc. This group, at the request and with the assistance of the Ford Foundation proposed to hold in December a mid-century conference on the wise use of our natural resources in the future.

* * *

Dr. A. Blaine Brower, Dayton, was given the Alfred Stengel Memorial Award for distinguished medical service at the American College of Physicians meeting in Atlantic City. He was cited for having established in 1950 an endowment to help young physicians participate as visiting fellows in postgraduate studies.

* * *

Dr. E. C. Baker, Youngstown, was presented the gold medallion, highest award of the American Cancer Society, at a special luncheon meeting in Youngstown.

* * *

Community health relationships were discussed by Mr. Hart F. Page, assistant director of public relations, Ohio State Medical Association, at the Fourth Annual Health Commissioners Institute, sponsored by the Ohio Department of Health, May 12-15, at Lake Hope Lodge. Dr. Donald A. Dukelow, consultant in health and fitness, Bureau of Health Education, American Medical Association spoke on "School-Community Joint Health Planning."

* * *

Two Ohio physicians hold key posts in the newly organized Interamerican Foundation for postgraduate Medical Education. Dr. George M. Guest, Cincinnati, is president, and Dr. Leon Goldman, Cincinnati, is one of the advisors. Purpose of the organization, with headquarters at 112 E. Chestnut St., Chicago 11, is to encourage exchange of educators, postgraduate students and research workers in the field of medicine and allied sciences in Latin and North American countries.

* * *

Dr. Howard D. Fabing, Cincinnati, was installed as president of the American Academy of Neurology at the group's annual meeting in Chicago in early April.

Use of G. Globulin in Polio . . .

Dr. Porterfield Issues Policy on Distribution of Ohio's Allotment Through Local Units Which in Turn Will Cooperate with Doctors

DR. JOHN D. PORTERFIELD, director of the Ohio Department of Health, has announced the Department's policy with respect to the allocation, distribution and usage of Ohio's allotment of immune globulin for the prevention of paralytic poliomyelitis.

The policy is another step in the over-all program of the Department in the allocation of immune globulin. It was worked out through the Advisory Committee on Allocation of Immune Globulin, a group composed of health officers, other physicians and lay persons. The committee's previous recommendations on use of immune globulin in the prevention and modification of measles were published in the May issue of *The Journal.* (The reader is referred to page 442 of that issue).

All immune globulin is being pooled and distributed through the U. S. Office of Defense Mobilization. The Ohio Department of Health has been designated as the agency through which Ohio's allotment will be distributed. The state committee will continue to function in an advisory capacity to the Department of Health and will deal with policy as the distribution and allocation program progresses.

As this issue of *The Journal* went to press, Dr. Porterfield said that he was expecting the first allotment of immune globulin from the national distributing agency about June 1.

Following is the policy issued by the Department of Health in a special memorandum to local health commissioners:

INITIAL DISTRIBUTION

The Department of Health of the State of Ohio, will receive during May, 1953, from the national allocating authority approximately 88,000 cc's or 8,800 10 cc doses of immune globulin as Ohio's initial supply. The Ohio Department of Health shall, as soon as possible, forward to each local health department an initial supply of immune globulin determined on the basis of one 10 cc vial per 2,000 population serviced by a local department.

In order that no local health department will receive less than a "working supply," those 36 local health departments servicing a population of 12,000 or less, will each receive six 10 cc vials. For each one of the remaining 122 health departments servicing a population of more than 12,000 the formula of one 10 cc vial per 2,000 population shall apply.

Based on the 1950 decennial census this initial shipment of immune globulin will consume approximately 35,000 cc's which represents approximately forty per cent of Ohio's allotment.

SUPPLEMENTAL DISTRIBUTION

The remaining 53,000 cc's of immune globulin shall be used to replenish the supplies of the local health departments as demanded by the case load. Immune globulin shall be apportioned on the basis of the actual need in a given community and one case report card must be on file in the Ohio Department of Health for every 60 cc's of immune globulin distributed.

Many of the smaller local health departments will require considerably more than the six 10 cc vials distributed by the initial allocation; however, based on the 1947 through 1951 experience we may anticipate 12 cases of poliomyelitis to be reported in Ohio during the month of May 1953 and approximately 50 cases reported during the month of June.

To ensure proper refrigeration it therefore becomes necessary to keep the undistributed balance of immune globulin in the Ohio Department of Health for allocation to local health departments as their needs arise.

The larger amounts of immune globulin allocated to the larger health departments must be kept under careful surveillance at all times and requisition for additional immune globulin shall be made to the Ohio Department of Health as the supply reaches a critically low level and depending upon the daily incidence of the disease.

In the smaller health districts the supply may be utilized very rapidly; consequently, telephonic communications may be utilized to replenish the exhausted supply.

Dosage of Immune Globulin to be Utilized for Paralytic Poliomyelitis Prevention—The dosage of immune globulin must be calculated on the basis of 0.14 cc per pound of body weight of the contact to be injected. Representative dosages as follows:

Weight	Dosage
25 lbs.	3.5 cc
50 lbs	7.0 cc
100 lbs.	14.0 cc
150 lbs.	21.0 cc

RECOMMENDED METHODS OF USAGE

Immune globulin shall be utilized only for the household contacts of a diagnosed case of poliomyelitis who are:

1. Over the age of three months but under the age of thirty years.
2. Pregnant women of any age.

Household contacts must be defined as those

individuals whether of the same family or not who **live within the same family unit as the diagnosed case.** The age limits of the eligible contacts were arrived at after very careful consideration of the age characteristics of the reported poliomyelitis in Ohio during recent years.

Pregnant women are slightly more susceptible to poliomyelitis than the average population and, therefore, shall be included when they fall within the household contact group. Members of the same family **not living at home** shall **not** be considered eligible for immune globulin.

It will be noticed that the initial allotment to Ohio of 88,000 cc's was calculated on the basis of 60 cc's times the 1,481 cases which represents Ohio's mean yearly incidence of poliomyelitis. On the average there should be approximately three household contacts for each reported case and as the average dosage will be 10 to 14 cc per contact, the 60 cc allotment per case should be ample to meet most local programs.

LOCAL DISTRIBUTION

Distribution of Immune Globulin by Local Health Departments to Local Practicing Physicians—The health commissioner shall be responsible for the immune globulin allocated to him by the Ohio Department of Health. It is, therefore, essential that the health commissioner have an accurate and authentic record of all globulin which he distributes. The form entitled "Physicians Report of a Case of Poliomyelitis and Request for Immune Globulin for Household Contacts" (furnished by the Department) would serve as such a record.

The first section of this card shall be completed by the physician making the diagnosis of poliomyelitis. The second section of the card shall be completed by the physician the family selects to provide protection to the rest of the family. Where conditions warrant, the family may bring the card directly to the local health commissioner with the first section completed and he may provide for completion of the second section by telephonic arrangement with the selected physician.

The health commissioner will be responsible for alloting to the physician the amount required to inject the listed household contacts based on the dosage of 0.14 cc per pound of body weight. As the immune globulin for use in the prevention of paralytic poliomyelitis will be distributed in 10 cc vials the supply which it will be necessary to allocate to the physician will occasionally be somewhat more than is requested.

In order to reduce duplication of reporting this completed form shall be considered a **report of a case** to the local health department. Since the health commissioner will want to keep these forms in his own department, a regular routine report card **must** be completed by the health commissioner upon receipt of this form, and sent in the routine fashion to the Ohio Department of Health.

SPECIAL ALLOCATIONS

Special Allocations of Immune Globulin for Epidemic Situations—It is recognized that in some communities where explosive outbreaks occur, an expanded system of usage might prevent more poliomyelitis than this basic plan. Extending eligibility to include contacts equally as intimate as household contacts would be one modification. Another would be the injection of the contacts of cases suspected but not yet diagnosed. A third modification would be the mass injection of all children and pregnant women in a community where an epidemic is occurring.

Modification of the basic plan may be undertaken only by arrangement between the local health commissioner and the Ohio Department of Health, where conditions warrant. The national allocating authority has a reserve supply of immune globulin for use in acute community situations upon demonstration by the State Health Officer that such conditions exist.

In order that the health department may be alert to all possible epidemic situations which will warrant expanded systems of usage, it is absolutely essential that all possible information concerning the incidence of the disease in the local communities be forwarded to the Ohio Department of Health. Reporting of cases to the Ohio Department of Health must be accurate and prompt. Cases must be recorded as paralytic, non-paralytic, or type undecided as shown on the request form.

The severity of the disease may well be assessed in terms of case fatality rate and it will be essential that deaths from poliomyelitis also be reported immediately to the Ohio Department of Health. The card form, (furnished by the Department) entitled "Report of a Death from Poliomyelitis," may be utilized for this purpose.

American Goiter Association Meets in Chicago

Several Ohio physicians took an active part in the annual meeting of the American Goiter Association in Chicago, May 7-9.

Dr. M. Dobyns and Dr. Sandord Steelman, Cleveland, presented discussions on "The Thyroid Stimulating Hormone (TSH) of the Anterior Pituitary as Distinct from the Exophthalmos-Producing Substance (EPS)."

Dr. George Crile, Jr., Cleveland, spoke on the subject, "Thyroiditis." He also took an active part as a member of the program committee.

Dr. George M. Curtis, Columbus, and Dr. Joseph L. DeCourcy, Cincinnati, are executive councilors of the Association.

Conference of County Society Officers . . .

Three-Fourths of Local Medical Societies Are Represented at Program Sponsored by Association in Cincinnati on Eve of 1953 Annual Meeting

SIXTY-SIX County Medical Societies were represented at the Annual Conference of County Medical Society Presidents, Secretaries and Committeemen, held on Monday afternoon, April 20, in Cincinnati, on the eve of the Annual Meeting, under sponsorship of the State Association.

The meeting followed a complimentary luncheon in the Pavillon Caprice of the Netherland Plaza Hotel.

The program high lighted four speakers and dealt with subjects of everyday interest to physicians in organized medicine and in practice—legislative matters and medical and hospital care programs for recipients of state welfare funds.

Dr. Harve M. Clodfelter, Columbus, then President of the Association, presided at the conference, assisted by Dr. Paul A. Davis, Akron, who has since succeeded him as President.

MILITARY SITUATION

"Doctors and the Military Situation," was discussed by C. Joseph Stetler, Secretary of the Council on National Emergency Medical Service of the American Medical Association.

Mr. Stetler dealt particularly with developments in Washington in regard to the new proposed Doctors' Draft Act and with actions the A. M. A. has and is taking with regard to this legislation. This situation was so fluid at the time Mr. Stetler spoke, that no effort was made to reduce his talk to writing for this report. Those present were apprised of developments up to that time and advised to keep in close touch with their representatives in Washington.

PUBLIC WELFARE RECIPIENTS

"Medical and Hospital Care Programs for Recipients of the Aid for the Aged," was discussed by Marion W. McIntyre, chief, Division of Aid for the Aged, Ohio Department of Public Welfare.

After outlining the program of his agency, Mr. McIntyre expressed the hope that liaison between doctors of Ohio and the personnel of the Division of Aid for the Aged could be extended by having a committee of the Association sit down with representatives of the agency to work out common problems.

Such a cooperative undertaking is now underway. The Committee on Public Relations and Economics of the Association has scheduled conferences for early this coming fall, during which it will analyze reports which have come to it from county society meetings and conferences and those coming from public assistance and social administration agencies and will attempt to work out satisfactory solutions to the growing problems.

"Medical and Hospital Care Programs for Recipients of Public Assistance," was discussed by Mr. Robert Canary, chief, Division of Social Administration, Department of Public Welfare. The Division headed by Mr. Canary administers programs of all recipients of public welfare funds other than for the aged. After explaining the working of the several medical and hospital care programs under his jurisdiction, Mr. Canary stressed the need of continuing cooperation between the medical profession and the administrative staff of his Division.

STATE AND NATIONAL LEGISLATION

Mr. Charles S. Nelson, Executive-Secretary of the Association, discussed the subject, "State and Federal Legislation." He called attention to the fact that there are some 80 bills before the Ohio General Assembly which have some medical or health connotation and which bear watching by the profession.

Mr. Nelson outlined several of the bills most important to the profession. He stressed the importance of doctors, especially officers and committeemen of county societies, keeping in touch with their representatives in the General Assembly and making known to them the desires of the profession when a medical or health question is involved. Mr. Nelson also pointed out that there are a number of bills before the Congress in Washington which are closely related to the profession's interests. Again he stressed the importance of continued communication with Congressmen and Senators in regard to Federal legislation as it develops. He pointed out that the A. M. A. maintains close liaison with the Congress in Washington and the State Association maintains liaison with the Ohio General Assembly, but that legislators look to their constituents back home for "grass-roots" reaction.

Those who registered at the conference were the following:

Officers and Councilors—H. M. Clodfelter, Columbus, President; Paul A. Davis, Akron, President-Elect; First District, D. W. Heusinkveld, Cincinnati; Second District, M. D. Prugh, Dayton; Third District, James R. Jarvis, Van Wert; Sixth District, Carl A. Gustafson, Youngstown; Seventh District, R. J. Foster, New Philadelphia; Eighth District, Robert S. Martin, Zanesville; Eleventh District, John S. Hattery, Mansfield.



County Society officers and committeemen are shown as they received first-hand insight into the doctor-draft from C. Joseph Stetler (inset), Secretary of the A. M. A. Council on National Emergency Medical Service, and one of the key speakers on the program.

Adams County—S. J. Ellison and Hazel L. Sproull, West Union.

Allen County—Lawrence N. Irvin, Lester C. Thomas and Edward B. Young, Lima.

Ashland County—C. R. Gibbons and Myron A. Shilling, Ashland.

Ashtabula County—S. A. Burroughs and Donald D. Forward, Ashtabula.

Athens County—L. I. Goldberg and C. R. Hoskins, Athens.

Auglaize County—Clyde W. Berry, Wapakoneta; and David W. Nielson, Waynesfield.

Butler County—Malcolm O. Cook and W. F. Hume, Hamilton.

Carroll County—Glenn C. Dowell and Carl A. Lincke, Carrollton.

Champaign County—V. R. Frederick, F. E. Lowry and I. Miller, Urbana.

Clark County—Martin J. Cook, William H. Crays, Francis C. Link and Ray M. Turner, Springfield.

Clermont County—J. M. Coleman, Loveland; John T. Crone, Milford; and Carl A. Minning, Batavia.

Clinton County—Robert Conard, Arthur F. Lippert, Robert E. Suer and Edmond K. Yantes, Wilmington.

Columbiana County—Paul W. Conrad, Leetonia; John A. Fraser, East Liverpool; J. R. Moorehead, Columbiana; and W. F. Stevenson, Salem.

Crawford County—E. C. Brandt and T. D. Sawyer, Crestline; Robert L. Solt, Bucyrus.

Cuyahoga County—John H. Budd, Joseph K. Doran, Donald M. Glover, H. A. Haller, C. R. Jablonoski, E. A. Marshall, George W. Petznick, R. J. Whitacre, Herbert B. Wright, Cleveland.

Darke County—E. W. Arnold, New Madison; J. E. Gillette, Versailles; Maurice Kane, Greenville.

Defiance County—D. J. Slosser, Defiance.

Delaware County—Edward C. Jenkins and F. M. Stratton, Delaware.

Erie County—D. R. Lehrer and H. W. Lehrer, Sandusky.

Fairfield County—Wm. S. Jasper, Pleasantville; and Chester P. Swett, Lancaster.

Franklin County—John E. Martin and C. C. Sherburne, Columbus.

Gallia County—M. J. Magnussen and Homer B. Thomas, Gallipolis.

Greene County—H. C. Messenger, Xenia; and L. W. Sontag, Yellow Springs.

Guernsey County—Olin R. Martin and James A. L. Toland, Cambridge.

Hamilton County—Ralph G. Carothers, Daniel Earley, J. Robert Hudson, Joseph Lindner, Rob-

ert C. Rothenberg, David Tucker, Foster M. Williams, Cincinnati.

Hardin County—Floyd M. Elliott, Ada.

Harrison County—C. F. Goll, Hopedale.

Highland County—John R. McBride, Hillsboro.

Hocking County—R. C. Jones, Logan.

Holmes County—Owen F. Patterson and N. P. Stauffer, Millersburg.

Huron County—H. A. Erlenbach, New London.

Jackson County—E. H. Stanley, Jackson.

Jefferson County—Irving Dreyer, Toronto; S. L. Burkhardt and Albert E. Winston, Steubenville.

Knox County—James C. McLarnan, Mt. Vernon.

Lake County—Morris G. Carmody, Painesville.

Lawrence County — Thomas E. Miller and George N. Spears, Ironton.

Licking County—James B. Johnson, James K. Nealon, R. G. Plummer, Newark.

Lorain County—Charles J. Cooley, Oberlin; and Leonard A. Stack, Lorain.

Lucas County—A. A. Brindley, Crawford L. Felker, David C. Frick, W. W. Green, John F. Hillabrand, M. R. McGarvey, James E. Mullen, Frederick P. Osgood, Toledo.

Mahoning County—L. H. Getty, Vernon L. Goodwin, Stephen W. Ondash, and Wm. M. Skipp, Youngstown.

Marion County—Clovis J. Altmaier, Marion.

Medina County—Morris Wilderom, Medina.

Meigs County—Roger P. Daniels, Pomeroy.

Mercer County—James J. Otis and Rudolph G. Schmidt, Celina.

Miami County—Dale A. Hudson, Piqua; George A. Woodhouse, Pleasant Hill.

Montgomery County—Robert C. Austin, A. V. Black, Homer D. Cassel, R. Dean Dooley, T. L. Light, George I. Martin, O. Wright, Dayton.

Muskingum County—W. L. Cruise, Zanesville.

Ottawa County—Geo. A. Boon, Oak Harbor

Pickaway County—V. D. Kerns and E. L. Montgomery, Circleville.

Pike County—C. L. Critchfield, Waverly.

Putnam County—Joseph J. McHugh, Ottawa.

Richland County—Charles R. Keller and F. M. Wadsworth, Mansfield.

Ross County—Ralph W. Holmes, C. N. Hoyt, F. W. Nusbaum, Chillicothe.

Sandusky County—Richard R. Wilson, Fremont.

Scioto County—Clyde M. Fitch and C. L. Pitcher, Portsmouth.

Seneca County—Walter A. Daniel and R. F. Machamer, Tiffin.

Shelby County—H. Eugene Crimm and George J. Schroer, Sidney.

Stark County—Roy H. Clunk, Lloyd L. Dowell, Massillon; R. L. Rutledge, Alliance.

Summit County—Millard C. Beyer, A. William Friend, Carl C. Nohe, Akron.

Trumbull County—E. R. Westbrook, Warren.

Tuscarawas County—H. E. Reed, Dover.

Union County—F. C. Callaway, Marysville; E. J. Marsh, Broadway.

Van Wert County—Roland H. Good, Van Wert.

Warren County—J. E. Sharts, Franklin.

Wayne County—Robert A. Anderson, William R. Schultz, Wooster.

Wood County—Paul F. Orr, Perrysburg; and F. F. Price, Stony Ridge.

Executive secretaries and others attending in an official capacity included: Messrs. H. Van Y. Caldwell, Cleveland; Stanley R. Mauck, Columbus; E. F. Willenborg, Cincinnati; Robert W. Elwell, Toledo; Robert F. Freeman, Dayton; E. M. Sprunger, Canton; Mr. Craig Wright, Columbus, winner of the first O. S. M. A. rural medical scholarship; and Messrs. Nelson, Saville, Page and Moore, Miss Okert and Miss Winzenried of the Headquarters Office.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association since April 10, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY

Downing, William C., Cleveland
Greicius, Francis A., Cleveland
Gruter, John H., Wooster
Harris, John W., Cleveland
Kennell, John H., Cleveland
Mayer, Robert E., Cleveland
McGovern, Edwin A., Cleveland
Murphy, Woodrow W., Cleveland
O'Connell, Frank B., Jr., Cleveland
Salus, Karl, Cleveland
Tauzeau, Arthur T., Cleveland
Wallace, William M., Cleveland
Ward, Creed F., Cleveland

ERIE COUNTY

Printy, James E., Jr., Sandusky

FRANKLIN COUNTY

Barton, Stanley L., Columbus
Filer, Lloyd J., Jr. Columbus
Hatfield, Paul M., Columbus
Hunt, William E., St. Louis, Mo.
Wenzel, Richard L., Columbus

HAMILTON COUNTY

Biehl, J. Park, Cincinnati
Kriauciunas, Juozas, Cincinnati
Overby, Harry Thomas, Cincinnati
Street, James B.

LAKE COUNTY

Zemzars, Janis, Perry

LUCAS COUNTY

Bowlus, Thomas P., Toledo
Burnside, Howard B., Toledo
Gordon, Horace G., Toledo
Hawkins, Robert C., Toledo
McAvoy, Harry D., Toledo
Wiltberger, Mary E., Toledo

MAHONING COUNTY

Gregg, Lester O., Youngstown
Lamprich, F. M., Youngstown

MONTGOMERY COUNTY

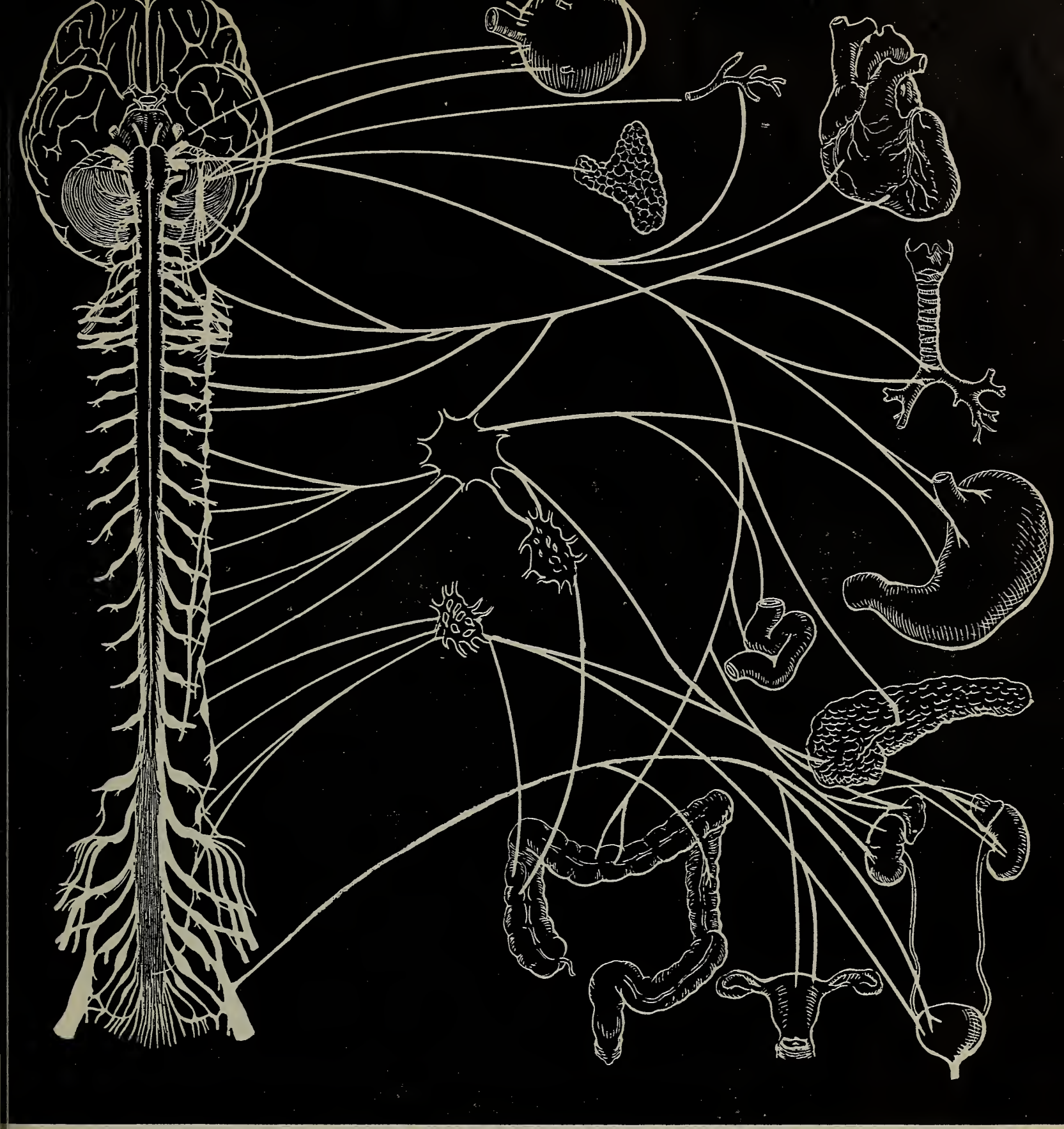
Appleton, James C., Dayton
Fanning, Robert A., Dayton
Nelson, Marion H., Brookville
Reed, Ernest C., Dayton
Teder, Richard T., Dayton

STARK COUNTY

Shaheen, Salem, Jr., Canton

SUMMIT COUNTY

Dix, John Harlan, Cuyahoga Falls



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RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

PG Course in Pulmonary Diseases . . .

O.S.U. College of Medicine, Tuberculosis Organizations and State Association Combine Forces To Sponsor Comprehensive Program

PLANNED especially for general practitioners, a postgraduate course in pulmonary diseases will be held at the Ohio State University College of Medicine and at the Neil House in Columbus, September 25 and 26.

Sponsored by the College of Medicine, Ohio Trudeau Society and Ohio Tuberculosis and Health Association and the Ohio State Medical Association, the cost of the course will be $15, and attendance will be limited to 150.

The course has been approved for nine hours credit by the Ohio Academy of General Practice.

Hotel reservations are to be arranged directly with the hotel of the registrant's choice. Course reservations may be made by sending a check in the amount of $15 to Mr. H. G. Howson, treasurer, in care of the Ohio Tuberculosis Hospital, Ohio State University, Columbus. A complete announcement of the course and registration blanks will be mailed to each member of the Ohio State Medical Association with an early issue of the *OSMAgram.*

As an additional attraction, arrangements have been made to secure a block of seats for the Ohio State University-Indiana football game at 2 p. m., Saturday, September 26, just following adjournment of the course. An additional amount of $3.50 per ticket should be included with the registration fee for those who wish to attend the game.

The complete program for the course is as follows:

FRIDAY, SEPTEMBER 25

Chairman: John A. Prior, M. D., professor and acting chairman, Department of Preventive Medicine, Ohio State University College of Medicine.

10:30-11:00 a. m.—Registration.

11:00-11:10 a. m.—Introductory Remarks, Charles A. Doan, M. D., dean, Ohio State University College of Medicine.

11:10-11:30 a. m.—"Bronchitis and Emphysema," Sidney E. Wolpaw, M. D., assistant clinical professor of medicine, Western Reserve University School of Medicine.

11:30-11:50 a. m.—"Modern Therapy of Asthma," John H. Mitchell, M. D., clinical professor (allergy), Department of Medicine, O. S. U. College of Medicine.

11:50 a. m.-12:00 noon—Intermission.

12:00 noon-1:00 p. m.—Carcinoma of Lung: Symposium (A) General Considerations; (B) Diagnosis; (C) Surgical Treatment; (D) Palliative Treatment.

Joseph L. Morton, M. D., associate professor, Department of Radiology, O. S. U.

Ulrich U. Henschke, M. D., associate professor, Department of Radiology, O. S. U.

H. G. Schlumberger, M. D., associate director of laboratories, professor, Department of Pathology, O. S. U.

Neil C. Andrews, M. D., assistant professor, Department of Surgical Research, O. S. U.

George O. Kress, M. D., clinical assistant professor (pulmonary diseases), Department of Medicine, O. S. U.

1:00-2:00 p. m.—Luncheon.

AFTERNOON SESSION

Chairman: Charles A. Doan, M. D., dean, Ohio State University College of Medicine.

2:10-2:50 p. m.—"Suppurative Diseases of the Lungs"—Panel Discussion;

Sidney E. Wolpaw, M. D., asisstant clinical professor of medicine, Western Reserve University School of Medicine;

Jack Wildrich, M. D., associate professor, Department of Radiology, O. S. U.;

P. B. Hardymon, M. D., associate clinical professor, Department of Surgery, O. S. U.

2:50-3:30 p. m.—"Pulmonary Tuberculosis: Diagnosis and Management," Herman J. Nimitz, M. D., assistant professor of medicine, University of Cincinnati College of Medicine.

3:30-3:50 p. m.—"Pulmonary Tuberculosis: The Practitioner's Role," Joseph B. Stocklen, M. D., assistant clinical professor of medicine and preventive medicine, Western Reserve University School of Medicine.

3:50-4:00 p. m.—Intermission.

4:00-5:00 p. m.—"Tuberculosis—Man and Society," Renè Dubos, Ph. D., member, Rockefeller Institute for Medical Research, New York City.

EVENING SESSION

Joint Session with the Columbus Surgical Society, Junior Ball Room, Neil House Hotel

6:15-7:00 p. m.—Cocktails.

7:00-8:30 p. m.—Banquet; Toastmaster: Karl P. Klassen, M. D., associate professor, Department of Surgical Research, O. S. U.

8:30 p. m.—"Recent Trends in Cardiac Surgery," Charles P. Bailey, M. D., professor of thoracic surgery, Hahnemann Medical College, Philadelphia, Pennsylvania.

SATURDAY MORNING SESSION

Chairman: R. H. Browning, M. D., professor of medicine (pulmonary diseases), Ohio State University College of Medicine.

9:00-9:20 a. m.—"Industrial Diseases of the Lungs," Raymond C. McKay, M. D., associate

New Horizons in Antibiotic Therapy

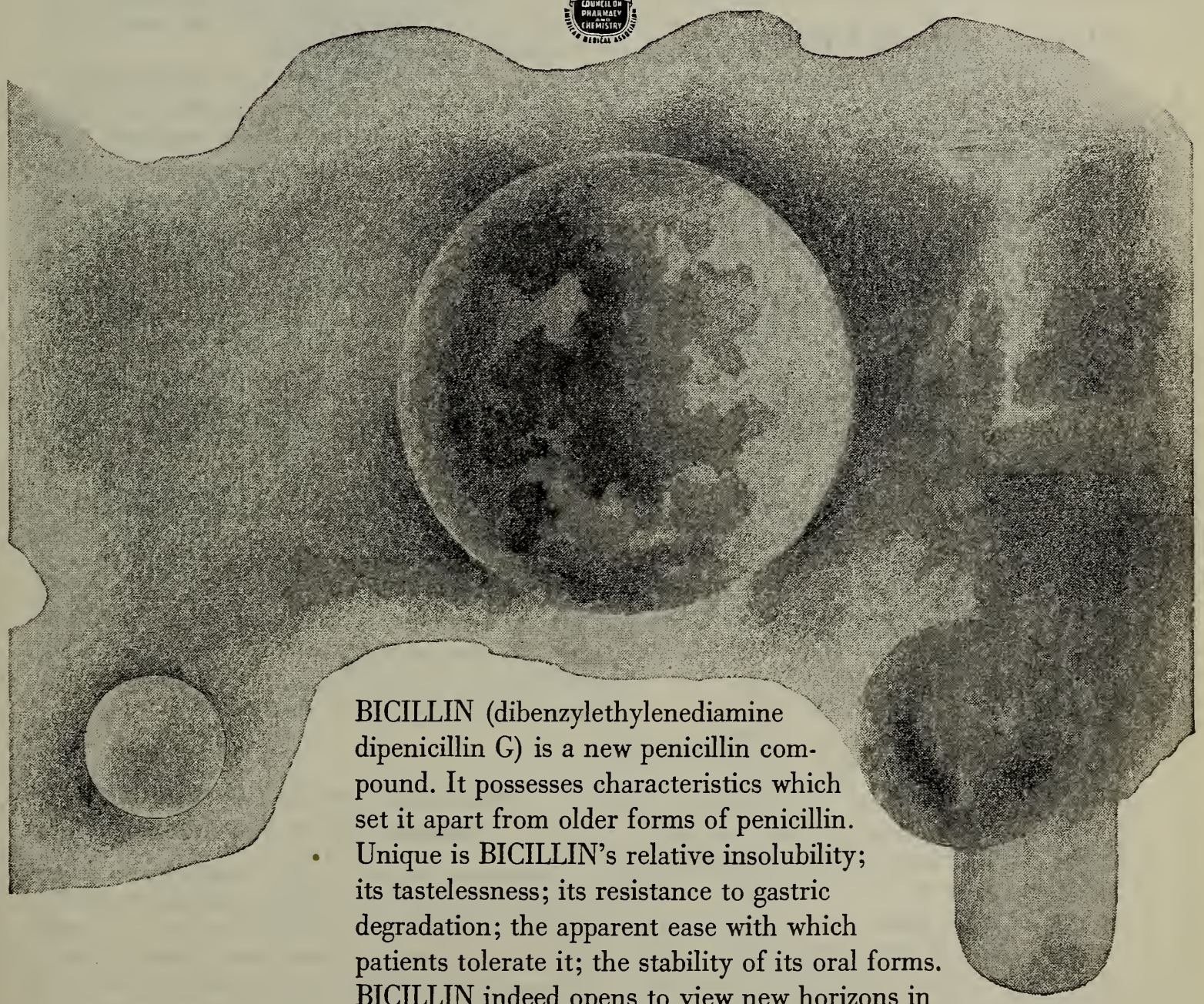
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clinical professor of medicine, Western Reserve University School of Medicine.

9:20-9:35 a. m.—"Diffuse Pulmonary Lesions," John A. Prior, M. D., professor and acting chairman, Department of Preventive Medicine, O. S. U.

9:35-9:50 a. m.—"Solitary Pulmonary Lesions," Karl P. Klassen, M. D., associate professor, Department of Surgical Research, O. S. U.

9:50-10:30 a. m.—Chest X-Ray Demonstration (A) Unusual Cases of Pulmonary and Mediastinal Disease; (B) Specialized Radiographic Techniques.

Benjamin Felson, M. D., professor and chairman, Department of Radiology, University of Cincinnati College of Medicine.

Joseph L. Morton, M. D., associate professor, Department of Radiology, O. S. U.

Jack Wildrich, M. D., associate professor, Department of Radiology, O. S. U.

Martha E. Southard, M. D., assistant professor, Department of Radiology, O. S. U.

10:30-10:45 a. m.—Intermission.

10:45 a. m.-11:30 a. m. Questions and Answers —"The Students Quiz the Faculty."

11:30 a. m.—Adjournment.

SATURDAY AFTERNOON SESSION
(Optional)

2:00 p. m.—Football—Ohio State University vs. University of Indiana.

Office Public Relations For the Busy Physician

Editor's Note: In order to provide tips for physicians in regard to good Public Relations procedures and practices in their offices, *The Journal* will present from time to time concise articles based on suggestions and recommendations made at A. M. A. Public Relations conferences and on articles published in other medical journals.

The third in the series follows:

COMMON SENSE IN PR

A PAST-PRESIDENT of the San Francisco Medical Society recently penned a few terse remarks which add up to practical public relations practice. There is nothing complicated about his advice. Here is an abstract of his letter, transformed into a sort of check list:

I. Provide the best possible medical care. There is no substitute for quality, and the American people are used to the best.

A. Make a man's right to go to the doctor of his choice even more attractive.

B. Provide the personal service he wants.

C. Do your own examining and thinking rather than hoping for a solution in a plethora of laboratory reports.

D. Patients are people, not case numbers . . . be glad to see them even if you are a little tired; be frank, be prompt and never give them the impression you are doing them a favor.

E. Give a bit extra; it won't hurt you. The housewife returns to the merchant who tosses another potato on the scale after he has weighed the pound.

II. Provide the best possible medical care at the lowest possible cost. Costs of illnesses may be reduced in many ways.

A. Don't sell short the lowly office visit and house call, they are still the most economical method of practice.

B. Use hospitals and tests only as necessary; these are the expensive items and patients should be informed that they are.

C. Don't forget that over-use affects the insured man as much as the one who pays his bills directly . . . the premium simply goes up.

D. Prescribe carefully. (Do you ever phone a patient's druggist to see how much the prescription will cost?)

E. A patient is entitled to know, if he wants to, what he is getting into financially. Fees must be realistically competitive and the uncertainty eliminated.

The doctor pointed out that physicians are in "rugged competition for keeps with government agencies, foundations and belt-lines." He concluded that, "We can't put a bargain price on our services like the mass production outfits do. But we can and do give more and better health services per dollar and can do even better. The mouse trap adage still applies."

Physicians Invited to Exhibit Medical Stamp Collections

Physicians throughout the country are invited to enter stamps in the third Medical Stamp Exhibit co-sponsored by the Cleveland Health Museum and the Garfield-Perry Stamp Club of Cleveland, July 11-27 at the Museum. Dr. A. B. Bruner of Cleveland is serving as consultant.

Acceptable categories include stamps concerned with medicine and surgery, medical schools and laboratories, medical congresses, U. S. commemorative medical portraits, public health, drugs, Red Cross, disaster and relief, cancer, tuberculosis, nurses, child welfare. Entry blanks may be obtained up to June 15 from the Cleveland Health Museum, 8911 Euclid Avenue, Cleveland 6.



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Modern facilities for physical therapy, occupational therapy, hydrotherapy, and mineral baths under supervision of physiatrists.

Have You an Article in this Issue?

The Stoneman Press will have the type standing on the June Ohio State Medical Journal until the *10th* of the month, and will furnish reprints of your article at the following prices:

	Reprint With Cover		Reprint Without Cover	
100—	4 pages	$20.00	4 pages	$17.50
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300—	"	30.00	"	23.50
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ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1952, BY KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand at January 1, 1952:		
Cash in Huntington National Bank		$ 12,559.85
Cash in Ohio National Bank (dues paid in advance)		38,340.00
U. S. Treasury and Savings Bonds		80,000.00
Total Cash and Bonds on Hand, January 1, 1952		$130,899.85
RECEIPTS		
Interest on U. S. Treasury and Savings Bonds	$ 2,000.00	
1952 Membership dues collected in 1952	75,870.00	
1953 Membership dues collected in 1952	47,475.00	
1952 Exhibit space collected in 1952	12,082.50	
1953 Exhibit space collected in 1952	4,434.00	
Banquet tickets sold, Annual Meeting	2,475.00	
Payment for collection of American Medical Assn. dues	1,643.26	
Ohio Public Health Assn. Refund	9.00	
A. M. A. Delegate Refunds	160.75	
Postage Repaid	17.36	
Ohio State Medical Journal Appropriation repaid	1,000.00	
Total Receipts		$147,166.87
Total To Be Accounted For (Includes 1953 Dues and 1953 Exhibit Payments, Collected in Advance)		$278,066.72
DISBURSEMENTS		
Ohio State Medical Journal	$ 24,000.00	
Executive Secretary, salary	11,600.00	
Executive Secretary, expense	1,629.99	
President, expense	368.85	
Stenographic and clerical personnel, salaries	18,897.52	
Council, expense	2,240.32	
A. M. A. Delegates, expense	2,870.86	
Conference of County Society Presidents and Secretaries	1,040.41	
Dept. of Public Relations:		
Director, salary	$9,860.00	
Director, expense	1,792.44	
Asst. Director, salary	5,560.00	
Asst. Director, expense	1,508.11	
Exhibits and newspaper publicity	826.23	
Literature	1,495.61	
Postage	1,589.36	
Supplies	267.05	
Miscellaneous expense	2,427.25	25,326.05
Standing Committees:		
Education	$ 3.00	
Public Relations and Economics	470.76	
Scientific Work	280.90	754.66
Special Committees:		
Auditing and Appropriations	$ 175.00	
Cancer	58.00	
Industrial Health	370.11	
Medical Care of Veterans	83.84	
Military Advisory	85.24	
Chairman, salary	6,000.00	
Rural Health	1,603.75	
School Health	576.11	8,952.05
Annual Meeting		18,771.99
Employees, bonus		1,200.00
Insurance, bonding, social security		1,892.07
Postage		1,000.00
Professional Relations Activity (OSMAgram and miscellaneous)		3,953.55
Rent		7,349.52
Retirement Fund		2,843.90
Rural Medical Scholarships		2,000.00
Stationery, printing, supplies		2,431.16
Telephone and telegraph		1,909.19
Disbursement for money advanced and repaid		1,162.11
Refunds: Banquet tickets, exhibit space, dues		137.00
Total Disbursements		142,331.20
Cash on Deposit and Bonds on Hand, December 31, 1952		
Huntington National Bank	$ 8,260.52	
Ohio National Bank (dues paid in advance)	47,475.00	
U. S. Treasury and Savings Bonds	80,000.00	
Total Cash and Bonds on Hand, Dec. 31, 1952		135,735.52
Total Accounted For (Includes 1953 Dues and 1953 Exhibit Payments, Collected in Advance)		$278,066.72

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets:		
Cash in Ohio National Bank		$ 2,130.30
Petty cash		20.00
Total cash		$ 2,150.30
Accounts receivable: Advertisers	$ 2,357.10	
Postage deposit	65.00	2,422.10
Total current assets		$ 4,572.40
Property Assets:		
Furniture and equipment (depreciated value)		$ 11,746.55
Total Assets		$ 16,318.95

LIABILITIES AND SURPLUS

Surplus, December 31, 1951	$ 15,947.68	
Net income for year ended December 31, 1952	371.27	
Total Surplus, December 31, 1952		$ 16,318.95

STATEMENT OF PROFIT AND LOSS

Income:		
Advertising, gross		$ 34,517.92
Less:		
Commission on advertising	$ 2,844.77	
Discount on advertising	816.65	3,661.42
Advertising income, net		$ 30,856.50
Ohio State Medical Association, appropriation		24,000.00
Subscriptions and sales		773.45
Miscellaneous Receipts: Postage advanced and repaid		32.43
Total Income, net		$ 55,662.38
Expenses:		
Journal printing	$ 39,035.11	
Salaries	10,181.60	
Employees' bonus	400.00	
Journal postage	881.52	
Illustrations and engravings	307.73	
Subscriptions to other publications	47.25	
Clipping service	300.00	
Office supplies and expense	2,253.87	
Auditing	120.00	
Miscellaneous postage	484.17	
Depreciation	1,279.86	
Total expenditures		$ 55,291.11
Surplus for the year		$ 371.27

50 YEARS AGO

". . . in all cases where the milk supply is not private and its conditions fully known, all milk for use in the nursery should be boiled immediately upon its arrival in the house. . . . Milk completely sterilized by several exposures to heat . . . and hermetically sealed, will keep sweet for many weeks, and this device is most valuable for long journeys or ocean voyages." (1)





Baker's Modified Milk *Powder* is suggested for baby's safety when traveling. Mother can put the prescribed amount of powder for each feeding in a capped, sterile nursing bottle and carry boiled water in a Thermos bottle. Each feeding can then be prepared just before use.

The powder is also especially adaptable for use wherever refrigeration facilities are not available. Here, too, individual feedings may be mixed as needed.



POWDER and LIQUID

Baker's Modified Milk is made from Grade A Milk (U. S. Public Health Service Milk Code), which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of carbohydrates, vitamins and iron.

BAKER'S MODIFIED MILK *POWDER FORM*

Simplifies infant feeding when traveling and whenever refrigeration facilities are not available

(1) Cheadle—*Artificial Feeding and Food Disorders of Infants*, Sixth Edition (1906)

BAKER'S MODIFIED MILK

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Main Office: Cleveland 3, Ohio
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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Dayton Health Forums . . .

Montgomery County Medical Society and Dayton Daily News Sponsor Series of Free Information Meetings; Public Response Is Excellent

NATION-WIDE interest has been drawn to Dayton and to the series of free health Forums sponsored by the Montgomery County Medical Society in cooperation with the *Dayton Daily News*.

Attendance at the first four of the series of forums was evidence of the public's stamp of approval on this plan of health education, declared county medical society officers. They further report that members of the Medical Society are enthusiastic in their praise of the forums as one of the finest public relations ventures ever undertaken by the Society.

Attendance at the meetings grew from 1,300 at the first session on April 22 to a near capacity audience of 2,000 at the fourth meeting. Plans are now in progress to resume the series in the fall.

Forums of this type, which were pioneered in Ohio by the Montgomery County Medical Society, also have been successfully run in St. Petersburg, Florida, and Atlanta, Georgia.

According to Dr. Richard S. Graves, chairman of the Public Relations subcommittee on Forums, numerous other county Societies throughout the country have asked for details on the Dayton plan with a view of starting their own.

COOPERATIVE ENDEAVOR

Dr. Robert C. Austin, president of the Montgomery County Medical Society, credits the *Dayton Daily News* with an outstanding job of promoting the Forums. According to Dr. Austin the *News* paid all of the costs of advertising which included from 8 to 10 spot announcements daily on radio and TV plus full page advertisements in the Sunday papers.

Auditorium facilities were furnished by the National Cash Register Company which provided its auditorium, with a seating capacity of 2,300, free of charge.

Topics for the discussions were selected by the Medical Society. The four chosen were: "Growing Old Gracefully"; "Your Life, Your Heart, Your Blood Vessels"; "The Common Headache"; and "Child Care During Polio Season."

Participants in the Forums were selected from physicians who volunteered their services. The programs opened with a one-minute welcome speech each by a newspaper official and a representative of the Medical Society. From then on the 90-minute program was in the hands of the doctors. A physician moderator introduced four panel members and then the key-note speaker. The latter highlighted the evening's topic with a 15 minute prepared speech. Following this was the question and answer session lasting about an hour and ten minutes. (The programs started at 8:15 sharp and ended promptly at 9:45.)

No questions were permitted from the floor, but were taken from those sent in by newspaper readers on the coupons carried in the daily newspaper.

PUBLIC ENTHUSIASTIC

(See Facing Page)

Dr. Graves remarked that one of the amazing features was the intense interest shown by the audience. There was none of the customary shuffling and whispering or leaving early. At least a hundred people were on hand at 7:00 p. m. waiting for the door to open—an hour and a quarter before the programs began.

The Public Relations Committee feels that the Forums have done an outstanding job in bringing the Medical Society before the people of the community in a favorable light. Dozens of complimentary letters and even wires have been received from persons ranging from a bank president to a C. I. O. committeeman.

SURGEON GENERAL'S COMMENTS

High praise was awarded the Dayton Forums by Dr. Leonard Scheele, Surgeon General of the United States Public Health Service, who stated after the April 22 forum: "Many Americans are unacquainted with the facts of health and illness.

"The efforts of the Montgomery County Medical Society and the *Dayton Daily News* to bring a program of health and education before the public through a device like the Miami Valley Health Forums are extremely worth while.

"As a result of this forum the citizens of Dayton and Montgomery County have had a rare opportunity to meet some of their communities' private physicians and ask them pertinent questions about significant health matters.

"To me this is a most effective way of making health interesting and understandable to the average citizen.

"The type of public service rendered by the county medical society and *The Daily News*, is a good example of cooperation in the public interest.

"The National Cash Register Co., which made its auditorium available for the health forums, must also be commended."

Here's How Public Responded to Dayton Forums



Here are some 1,300 people who responded for the first public forum sponsored by the Montgomery County Medical Society in cooperation with the Dayton Daily News. The crowd swelled to 2,000 at subsequent meetings in the series of four.

A Tribute to Ohio's Early Doctors . . .

As Part of the Ohio Sesquicentennial Celebration, State Association Will Erect Memorial Marker at Fort St. Clair in July 4 Ceremonies

AS a part of the Ohio Sesquicentennial celebration, members of the Ohio State Medical Association will this year pay tribute to their medical colleagues who served in the Ohio Country during the Indian Wars.

On July 4, at Fort St. Clair, near Eaton, Dr. Paul A. Davis, Akron, president of the Association will deliver a dedicatory address in connection with the erection of a marker which contains a short history of the campaign and a roster of physicians who gave their services.

The sesquicentennial committee of the Association has prepared text material for the marker, and with the approval of The Council, a cast aluminum monument has been prepared.

The physicians to be honored served during the 1790's in the wilderness later to become Ohio, in the respective campaigns of Generals Josiah Harmar, Arthur St. Clair and Anthony Wayne.

The defeat of the Indians by General Wayne in his campaign of 1793 and 1794 was, according to historians, in a great measure made possible by the skill and devotion of these early medical heroes, who were commissioned officers serving in the Army of the United States or with the Kentucky Volunteers.

In 1794 the Indians were defeated at the battle of Fallen Timbers, and a year later the Treaty of Greene Ville brought peace to the Ohio frontier.

The address by Doctor Davis will pay tribute to the Indian War medical men and to the long list of Ohio physicians who have served their country since Ohio became a state in 1803.

BOOKLET PUBLISHED

In connection with the project the Association has published a 40-page book, *Physicians and the Indian Wars*, which narrates in detail the work of the doctors during the campaigns; the prevailing concepts of health and disease during the period; the education of the pioneer physician;

(Continued on page 562)

When organisms resist the other



antibiotics . . .



USE ERYTHROCIN*

...especially effective against gram-positive organisms including those resistant to penicillin and the other antibiotics.



USE ERYTHROCIN*

. . . has low toxicity; orally effective against infections caused by staphylococci, streptococci and pneumococci.



USE ERYTHROCIN*

. . . indicated in pharyngitis, tonsillitis, scarlet fever, pneumonia, erysipelas, osteomyelitis and pyoderma.



USE ERYTHROCIN*

...gastrointestinal disturbances mild and relatively rare; no serious side effects reported.



USE ERYTHROCIN*

. . . fully potent; average adult daily dose 0.8 to 2.0 Gm., depending on type, severity of infection.



USE ERYTHROCIN*

...special absorption-favoring coating; 0.1 Gm. (100 mg.) tablets supplied in bottles of 25 and 100. Abbott

* *Trade Mark for*
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1-178

medical agents and equipment used; and a list of medical officers participating.

The book is a compilation of the works of eminent medical and research historians, edited by the Sesquicentennial Committee of the Ohio State Medical Association under the direction of Doctor Jonathan Forman, Columbus. Others on the committee are: Doctors Cecil Striker, Cincinnati; David A. Tucker, Jr., Cincinnati; Howard Dittrick, Cleveland Heights; Eugene A. Ockuly, Toledo; Leon Goldman, Cincinnati; and James J. Tyler, Warren.

Material on early medical education was assembled by Linden F. Edwards, Ph. D., professor of anatomy, Ohio State University. Richard C. Knopf, research historian, Anthony Wayne Parkway Board, provided the complete list of doctors serving in the wars and their biographies.

Also cooperating were Gilbert F. Dodds, research associate, Franklin County Historical Society; Virginius C. Hall, director, Ohio Historical and Philosophical Society; and J. Richard Lawwill, director of the Anthony Wayne Parkway Board.

COUNTY SOCIETY PROJECTS

The Mercer County Medical Society will erect a plaque at Fort Recovery, honoring Doctor Victor Grasson, a doctor who was killed while caring for the wounded at that site during St. Clair's defeat by the Indians November 4, 1791.

The Academy of Medicine of Cincinnati will honor Dr. Richard Allison, the senior surgeon of the Indian Wars, who later became a resident of Cincinnati. A marker will be erected near the site of his office, at Third and Ludlow Streets in that city.

The text of the Fort St. Clair marker will read as follows:

PHYSICIANS IN THE INDIAN WARS

Pioneer physicians came into the wilderness that was to become Ohio in the 1790's, to serve in the respective campaigns of Generals Josiah Harmar, Arthur St. Clair, and Anthony Wayne in their struggle against the hostile Indians.

Their philosophy of service was expressed by Doctor Joseph Strong, one of their number, when he wrote here at Fort St. Clair on August 22, 1793:

> "May the glowing virtues in each heart kindle a vestal flame in the soul, which shall shine like the light of peace on the haggard faces of distress and illuminate the mysteries of human existence."

In 1794 General Wayne defeated the Indians at Fallen Timbers, and a year later the Treaty of Greene Ville brought peace to the frontier.

This marker, erected July 4, 1953, during the Sesquicentennial year of the statehood of Ohio, by the Ohio State Medical Association, is dedicated to the early medical men in the Ohio Country.

(Text for reverse side of marker)

ROSTER OF PHYSICIANS IN THE INDIAN WARS

In the Indian Wars physicians were commissioned officers—Surgeons and Surgeons' Mates, serving in the Army of the United States or with the Kentucky Volunteers. The defeat of the Indians by General Anthony Wayne in his campaign of 1793-1794 was in a great measure made possible by the skill and devotion of these physicians. Doctor Richard Allison, a veteran of the American Revolution, was the Senior Surgeon in this campaign, as well as in the previous campaigns under General Josiah Harmar and General Arthur St. Clair. He was aided by:

Surgeons

Charles Brown
Adam Rankin
Frederick Ridgly
John M. Scott
Joseph Waldo
John Elliot
John Knight
Joseph Phillips
James Speed
John F. Carmichael
Nathan Hayward

Surgeons' Mates

Charles Adams
Joseph Boswell
Thomas A. Claiborne
John Cornman
Samuel Downing
Richard Griffith
Thomas Hutchins
John R. Lynch
Samuel H. Marlow
Joseph Strong
John C. Wallace
Joseph Andrews
Samuel Boyd
James Clayton
Frederick Dalcho
Thomas Farley
John Hamill
William Lawton
William A McCrea
John Sellman
Elijah Tisdale
Charles Watrous
George Balfour
Francis G. Brewster
John C. Coffin
David Davis
Victor Grasson
John Hunter
Elihu Lyman
William McCroskey
Jeremiah Shannon
Thomas J. Van Dyke
James Woodhouse

Dr. F. Bayless Heads Cleveland Society of Pathologists

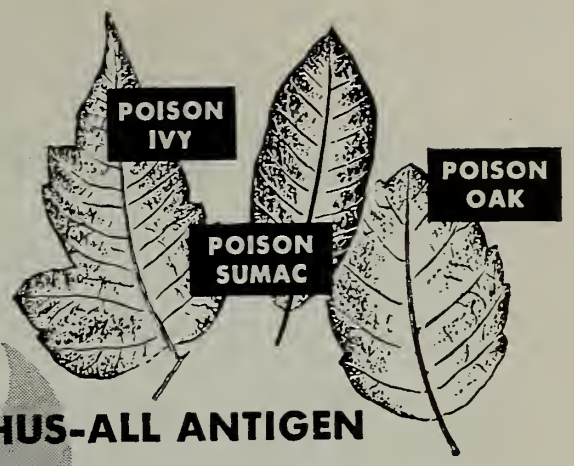
At the April meeting of the Cleveland Society of Pathologists, held at the Cleveland Clinic, Dr. Francis Bayless was elected president. Dr. Bayless had been secretary of the society for eight years and was president of the Academy of Medicine of Cleveland in 1950. He was president of the Ohio Society of Pathologists in 1949.

Other officers elected are: Dr. John Mackrell, Fairview Park Hospital, vice-president, and Dr. William Sinclair, Jr., Lutheran Hospital, secretary-treasurer. Dr. John B. Hazard, Cleveland Clinic, and Dr. Edward Goodsitt, Huron Road Hospital, were elected to the executive committee.

GI Loan Approval Should Be Sought Early

Veterans who plan to seek GI loans from private lenders for homes, farms or businesses should apply to Veterans Administration regional offices in advance for certificates of eligibility. V. A. announced that this will reduce delays in processing the loan applications later, when the veteran is anxiously awaiting completion of the deal or is pressed for time to close the loan.

Summertime protection from



RHUS-ALL ANTIGEN

Rhus-All Antigen is a unique sterile almond-oil solution of the active principles extracted from the leaves of Poison Ivy, Poison Oak and Poison Sumac.

Rhus-All Antigen prevents all three common types of Rhus Dermatitis. Only one or two injections are usually sufficient to offer protection.

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Please send me the following:

_____Vials (5 cc.) of Rhus-All Antigen No. 150-5. Physicians' price $2.00. SPECIAL OFFER: 1 extra with order of 5 vials.

_____Regular set (four 1 cc. vials) Rhus-All Antigen No. 150. Physicians' price $3.25. SPECIAL OFFER: 1 extra with order of 3 sets.

_____Complimentary copy of "Handbook of Allergy for the General Practitioner."

DR._____

STREET_____

CITY_____ STATE_____

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL

(Organized 1881)

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OBSTETRICS AND GYNECOLOGY

A full time course. In Obstetrics: Lectures; pre-natal clinics; witnessing normal and operative deliveries; operative obstetrics (manikin). In Gynecology: Lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Anesthesia. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

COURSE FOR GENERAL PRACTITIONERS

Intensive full time instruction covering those subjects which are of particular interest to the physician in general practice. Fundamentals of the various medical and surgical specialties designed as a practical review of established procedures and recent advances in medicine and surgery. Subjects related to general medicine are covered and the surgical departments participate in giving fundamental instruction in their specialties. Pathology and radiology are included. The class is expected to attend departmental and general conferences.

SURGERY AND ALLIED SUBJECTS

A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departmental and general conferences.

ANESTHESIA

A three months full time course covering general and regional anesthesia, with special demonstrations in the clinics and on the cadaver of caudal, spinal, field blocks, etc.; instruction in intravenous anesthesia, oxygen therapy, resuscitation, aspiration bronchoscopy.

FOR INFORMATION ABOUT THESE AND OTHER COURSES ADDRESS—
THE DEAN, 345 West 50th Street, New York 19, N. Y.

Licenses Granted by Endorsement . . .

Additional Lists of Doctors of Medicine, Certified To Practice in Ohio Through Reciprocity, Are Announced by the State Medical Board

THE State Medical Board of Ohio has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsements of their licenses to practice in other states (intended residence and medical school of graduation also are given):

December 2, 1952—William E. Todd, Columbus, University of California.

January 13—Jacob Adler, Cincinnati, University of Vienna; Harrison M. Baker, Cincinnati, University of California; Howard B. Burnside, Toledo, Wayne University; Alfons Ceicys, Canton, University of Kaunas; Simon W. Chiasson, Youngstown, McGill University;

Morris M. Deitchman, Youngstown, University of Illinois; Edward F. Dunne, Cleveland, University College of Dublin; John G. Esch, Cleveland, Creighton University; Leonard F. Fagnano, Youngstown, Northwestern University; Amasa B. Ford, Cleveland, Harvard; Walter E. Furr, Jr., Cleveland, Northwestern University;

Marvin Goldstein, Columbus, Jefferson Medical College; Harry N. Graubarth, Dayton, Tulane University; Joseph J. Haber, Cleveland, University of Vienna; Cornelius E. Healy, Cincinnati, University of Illinois; James S. Hewlett, Cleveland, University of Louisville; Carl W. Hoch, Cleveland, University of Pittsburgh;

Philip C. Johnson, Jr., Dayton, University of Michigan; Edwin R. King, Cleveland, Howard University; Arthur L. Knight, Ravenna, Dalhousie University; Saul R. Korey, Cleveland, University of Western Ontario; Robert E. Miller, Findlay, University of Wisconsin;

Ernest M. Newkirk, Columbus, Meharry Medical College; George F. Parker, Springfield, State University of Iowa; Lester Persky, Cleveland, Johns Hopkins University; William W. Richardson, Columbus, University of Pennsylvania; Robert R. Roberts, Akron, Hahnemann Medical School; Jack F. Ross, Cleveland, University of Michigan;

Alexander Salamon, Hamersville, University of Prague; Louis Schwab, Cincinnati, Harvard; Beecher W. Sitterson, Cincinnati, Harvard; Alexander Suszkiw, Columbus, University of Cracow; Bernard Taylor, Youngstown, University of Edinburgh; Emmet J. Thorpe, Cleveland, George Washington University; Jeanette M. Troup, Akron, Hahnemann Medical College;

Luella B. Voogd, Cleveland, State University of Iowa; Robert L. Wall, Columbus, Temple University; Harvey M. Watkins, Elyria, University of Louisville; Myron J. Welty, Berea, Medical College of Alabama; Stanley J. Wolfe, Cincinnati, Harvard;

John J. Yaeger, Columbus, Georgetown University; Wallace Zernich, Akron, University of Pittsburgh; John L. Zimmerman, Toledo, University of Michigan.

April 7—Richard W. Artz, Bryan, Columbia University; Jurgis Balciunas, Cambridge, University of Kaunas; Robert J. Banker, Akron, Northwestern University; Rudolph V. Basso, Dayton, University of Vienna; John K. Bembenista, Cleveland, University of Buffalo; Richard S. Benua, Cleveland, Johns Hopkins University; Charles I. Binder, Columbus, University of Minnesota; Mier Bizer, Cincinnati, University of Louisville;

Lawrence O. Carpenter, Akron, Western Reserve University; Bernard Chojnacki, Dayton, Georgetown University; Edward R. Christian, Dayton, University of Kansas; Paul H. Curtiss, Jr., Cleveland, University of Wisconsin; Raymond W. Dasso, Findlay, University of Illinois; Daniel Deitch, Bellaire, University of Illinois; Albert M. Doswald, Youngstown, University of Zurich; William R. Drucker, Cleveland, Johns Hopkins University;

Bruce C. Ehmke, Columbus, State University of Iowa; Charles J. Epstein, Cleveland, Yale University; Edward S. Eylander, Dayton, University of Washington; Gordon L. Farrell, Euclid, St. Louis University; Charles D. Fess, Findlay, University of Michigan; Arthur R. Fleming, Gallipolis, Temple University;

Robert K. Gardner, Cleveland, University of Maryland; Sanford F. Gaylord, Cleveland, The Chicago Medical School; Shirley W. Gregory, Warren, Howard University; Paul L. Grosner, Toledo, University of Vienna; Donald B. Hackel, Cleveland, Harvard; Norman B. Hasler, Lima, Indiana University; Rupert A. Havill, Warren, University of Rochester; Steve E. Hood, Jr., Jackson, University of Tennessee; Murray B. Hunter, Bellaire, Duke University;

Harold N. Johantgen, Shelby, Indiana University; John A. Kenney, Jr., Cleveland, Howard University; Edward A. Klauber, ...-, Long Island College; Marion E. Lahey, Cincinnati, St. Louis University; Henry B. Larzelere, Toledo, Northwestern University; Milton D. Levine, Bellaire, Johns Hopkins University; Jack K. Lewis, Akron, University of Chicago; James O. Ludwig, Mansfield, University of Pittsburgh;

John A. MacLeod, Cincinnati, Harvard; Robert J. McCandliss, Findlay, University of Michigan;

read Pfizer Spectrum weekly in the J.A.M.A.

to control fulminating sepsis

Intravenous Terramycin therapy in over 100 cases of surgical sepsis following operations of the thorax, abdomen or limbs gave "some but the most favorable results. The well-known side-effects in connection with orally administered antibiotics . . . were never found to occur, nor did we at any time observe any other toxic reactions."

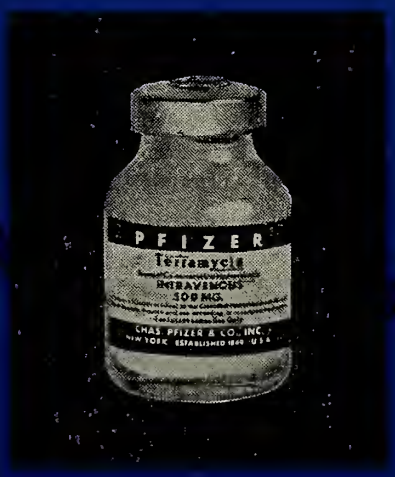
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broad-spectrum

Terramycin Intravenous

well-tolerated

Vials of 250 mg. and 500 mg.



in infants and children

"Our experience with Terramycin by the intravenous route has been good. It has been effectively used without difficulty by continuous drip infusion for several days in the smallest infant . . ."

Farley, W. J., Kaufman, L.: J. Pediat. 42:177 (Feb.) 1953.

as well as adult patients

Intravenous Terramycin, followed by oral therapy after 3-5 days, "is a clearly effective, superior antibiotic in the treatment of peritonitis and . . . a good result can frequently be obtained with this drug when [other antibiotics] have failed. It thus has great usefulness both as a primary therapeutic agent and as an alternate antibiotic."

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Pfizer

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Brooklyn 6, N. Y.

Arthur H. Mercer, ..., Dalhousie University; Emwood E. Odom, Cleveland, Howard University; John A. Ordway, II, Cincinnati, Columbia University;

Dwain J. Paal, Zanesville, Marquette University; Harvey J. Post, Cleveland, The Chicago Medical School; Ralph W. Powell, Wooster, Duke University; Franklin P. Reulbach, Cleveland, St. Louis University; William H. Roberts, Toledo, University of Tennessee; Juan Rodriguez-Trias, Cleveland, University of Louisville;

Kurt O. Schlesinger, Cincinnati, University of Illinois; Alwin E. Schultz, Lakeview, University of Wisconsin; Harry W. Slade, Cleveland, Baylor University; William F. Stewart, Rittman, University of Georgia; Henry H. Swain, Cincinnati, University of Illinois; William Swanton, Springfield, The Society of Apothecaries of London, England;

James L. Titchener, Cincinnati, Duke University; Joseph F. Tomashefski, Columbus, Hahnemann Medical College; Douglas J. Thompson, Findlay, University of Virginia; Harry G. Thompson, Portsmouth, Temple University; Paul S. Tucker, Fairborn, Loyola University; Robert Upson, Cleveland, Tufts College; Homer C. Wasson, Jr., Akron, University of Pittsburgh; Jesse R. Wilson, Jr., Cincinnati, Johns Hopkins University.

Pan American Women Doctors To Meet in New York

The IV biannual meeting of the Pan American Medical Women's Alliance will be held in the Beekman Tower Hotel, First Ave. and 49th Street, New York City, September 24-October 3. Graduates of accredited medical schools are eligible to attend. Papers are solicited from the different fields of medicine, especially in the field of public health and nutrition, since these are of special interest to visiting Latin American doctors. Communications should be addressed to: Dr. Eva Goddin Cutright, chairman, Program Committee, Wooster, Ohio.

Cuyahoga County's new $700,000 morgue, located at 2121 Adelbert Road, Cleveland, was dedicated May 14. Dr. Samuel Gerber, county coroner, described the establishment as the "finest morgue in the world." It houses 13 laboratories, an amphitheater for 50 students and crypts for 60 bodies. The morgue is operated in cooperation with the Western Reserve University School of Medicine and the Law School.

James E. Stuart, executive director, Hospital Care Corporation, (Blue Cross) Cincinnati, was reelected chairman of the Blue Cross Commission of the American Hospital Association at the Commission meeting held on April 16 in Hollywood, Florida.

The Knox Gelatine Diet and the Convalescent Child



Convalescence is associated with protein loss of serious magnitude, yet little is known of the fundamental nature of the loss.[1] Loss of nitrogen cannot be prevented; however, nitrogen balance can be maintained, wound healing enhanced, and convalescence shortened, by a high protein diet.[2]

Otherwise the patient uses his own "available" nitrogen stores to accomplish the healing defect.[3]

The patient "is better off before his nitrogen stores have been wasted than after. Surgeons have long noted that chronically debilitated patients are poor operative risks."[1] Decubitus ulcers heal quickly in heavily protein-fed patients.[4]

These facts are clear, as is also the fact that Knox Gelatine, which is pure protein, offers a useful method of supplementing the ordinary dietary protein.

Knox Gelatine is easy to digest, while its supplementary dietary nitrogen will furnish protein without other substances, especially salts of potassium which are retained during convalescence; without excess fat and carbohydrate, which are not needed especially; and without a food volume which may interfere with intake.

1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.
2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.
3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.
4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Shafiroff, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.



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KNOX GELATINE U.S.P. ALL PROTEIN NO SUGAR

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

EISENHOWER BOOSTS MEDICAL EDUCATION FUND

The financial crisis facing medical schools is a "dangerous threat to the national welfare, which must be met," President Eisenhower said recently in opening the $10,000,000 campaign within industry and the medical profession to help the schools overcome deficits threatening their teaching and research programs.

The President's views were expressed in a letter to S. Sloan Colt, New York banker and president of the National Fund for Medical Education. One paragraph of the letter said:

"As I wrote to you on January 6, the financial problems of the medical schools should be solved through private, rather than governmental means. Excessive reliance on government violates the essential principle of our free enterprise system. It falls, then, upon American business to assume a greater share of the responsibility for maintaining the institutions essential to our national health."

All of which prompts us to inquire: Have you made your contribution to the A. M. A. Medical Education Foundation which is a part of the National Fund for Medical Education? If not, better think it over and contribute. That's one way you can help keep the Federal Government out of our medical schools.

DOCTORS DRAFT LAW RECOMMENDATIONS CITED

Physicians who are interested in official views on the bill before Congress to re-enact the Doctors Draft Law (most physicians are or should be interested in this subject) should read the resolution on this question adopted by the House of Delegates of the Ohio State Medical Association at the recent Cincinnati Annual Meeting. It will be found in the transactions of the House of Delegates, published elsewhere in this issue of *The Journal.* Copies of the resolution were sent to all of Ohio's Congressmen.

Also, they should read the article which appeared on page 166 of the May 9 issue of *The Journal of the A. M. A.* In that article appeared the official statement filed with Congress by the A. M. A.

The bill has passed the House of Representatives and is now being heard by the Senate Committee on Armed Services. Many of the recommendations of the A. M. A. and the Ohio State Medical Association appear in the bill as it passed the House. There is reason to believe that the final enactment will produce a law which will be a distinct improvement over the current Doctors Draft Law.

AN IMPORTANT COURT DECISION

"The Bill of Rights Survives a New Attack" was the headline which appeared over an editorial published in a recent issue of the *Saturday Evening Post.*

Because you may have overlooked it and because Edward A. Rumely, mentioned in the editorial, has been a staunch crusader against socialized medicine, as well as all other kinds of socialism, we are re-producing the article. Said the *Post*:

In an important Supreme Court opinion a few weeks ago, Justice William O. Douglas struck a blow for liberty which has been too little noticed. One reason for the apparent blackout of "liberal" comment on this decision is probably the fact that Edward A. Rumely, the man who won this important battle for freedom of the press, represents the so-called "Right." Had he been a communist or a member of some bizarre religious sect, we should have heard a great deal more about his case.

It will be recalled that Doctor Rumely, as secretary for the Committee for Constitutional Government, was ordered by a congressional committee investigating lobbying to turn over to the committee a list of all purchasers of books which the committee had been selling to its members and others sympathetic to its ideas. The idea was that Doctor Rumely's outfit was attempting to influence Congress via the public. This was supposed to be lobbying.

In the course of his appearance on June 6, 1950, before the committee, of which the late Congressman Frank Buchanan was chairman, Doctor Rumely said that he was willing to produce the names of all contributors and the records of all loans and other transactions. But he added, "I'm not going to produce the names of people who bought books because under the Bill of Rights that is beyond the power of your committee to investigate."

The House cited Doctor Rumely for contempt of Congress, and his case dragged along through the Federal courts until it reached the Supreme Court, where the right of Doctor Rumely and all other Americans to publish and circulate books without supplying the names of the buyers to public authority was unanimously sustained.

Concurring with Justice Frankfurter's majority opinion, Justice Douglas wrote:

"We have here a publisher who through books and pamphlets seeks to reach the minds and hearts of the American people. . . . Like the publishers of newspapers, magazines, or books, this publisher bids for the minds of men in the marketplace of ideas. . . . The command that 'Congress shall make no law . . . abridging the freedom of speech or of the press' has behind it

a long history. It expresses the confidence that the safety of society depends on the tolerance of Government for hostile as well as friendly criticism, that in a community where men's minds are free, there must be room for the unorthodox as well as the orthodox views."

It would be difficult to find two sets of ideas more hostile to each other than those of Justice Douglas and the Committee for Constitutional Government. The justice's opinion does honor to his integrity and his ability to interpret American doctrine without regard for his taste in ideologies. Coming to the central issue of whether the publication and distribution of books can be penalized under a statute to control lobbying, Justice Douglas wrote: "Once the Government can demand of a publisher the names of the purchasers of his publications, the free press as we know it disappears. Then the specter of a Government agent will look over the shoulder of everyone who reads."

It seems to us that the Supreme Court's verdict in the Rumely case belongs with those important decisions by the court which in critical times put America more firmly on the right course, the course in line with her historic traditions.

"A SENSIBLE TAX RELIEF PROPOSAL"

Ohio's newest representative in the Congress, Oliver P. Bolton, Mentor, Ohio, has presented a bill, H. R. 3911, which is receiving an unusual amount of favorable comment in the press and which undoubtedly is popular with the average citizen.

The proposal seeks to amend the Internal Revenue Code to remove the limitations on the amount of medical and dental expenses which may be deducted on income tax returns.

Here's what the *Cleveland Plain Dealer* had to say editorially about Mr. Bolton's bill under the heading: "A Sensible Tax Relief Proposal."

"One of the soundest proposals to give tax relief to those who are most in need of it has been introduced in the House of Representatives by Congressman Oliver P. Bolton, Republican, of Ohio. His bill would permit the deduction from taxable income of all medical expenses, including the cost of belonging to voluntary hospitalization and medical insurance plans.

"At present only taxpayers past the age of 65 may deduct all their medical and hospita expenses. Those below that age may deduct only such expenses which are in excess of 5 per cent of their gross incomes, which means that a taxpayer must run up a sizable bill for sickness and injury before he can obtain any tax relief.

"Bolton's proposal might also be regarded as a health measure, since it would be an inducement to people to join medical and hospitalization plans and to seek medical care when they need it, without waiting too long. They would know that they would receive partial compensation for the expenses involved in the form of lower income taxes.

"This bill is far preferable to any form of socialized medicine that could be devised. It makes better sense to have the Government encourage people to look after their own health and to help them finance the cost through income-tax relief, instead of taxing everybody to estab-

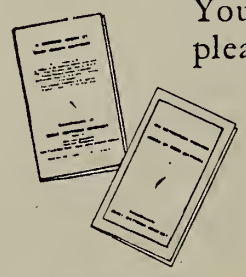


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lish a system of supposedly free Government medicine."

It is suggested, if you agree this is a sensible tax relief proposal, that you drop a line to your Congressman and request him to give Mr. Bolton some support in getting his measure through Congress.

HOW DOES YOUR DIATHERMY APPARATUS STACK UP?

If you have diathermy apparatus, is it in conformity with government regulations? Better check into this. It must meet certain regulations.

After June 30, 1953, it is unlawful to operate nonconforming diathermy apparatus. The Federal Communications Commission has been most cooperative with the medical profession and manufacturers by extending for one year the deadline for replacing non-conforming diathermy equipment. After June 30, 1953, all outmoded diathermy equipment used for therapeutic purposes must meet the requirements of the Federal Communications Commission. Surgical diathermy apparatus is exempt.

Information assembled by the Council on Physical Medicine and Rehabilitation of the A. M. A. indicates that there are a relatively large number of nonconforming diathermy apparatus being used in departments of physical medicine, in hospitals, in related institutions, and by physicians in their offices. To avoid a last-minute rush for equipment, physicians are advised to look into the available supply. A list of accepted diathermy apparatus may be obtained by writing to the Council on Physical Medicine and Rehabilitation at 535 North Dearborn St., Chicago 10, Illinois.

Supplement to the List of Films For Use Now Available

The Committee on Medical Motion Pictures of the American Medical Association has announced the publication of a supplement to the list of health education motion pictures cleared for use on television. This supplement lists 38 motion pictures which have been cleared for television use since publication of the original list in 1951.

Copies may be obtained by writing to the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10.

Conference on Aging

"Careers for Maturing Workers" will be the theme of the University of Michigan's sixth annual conference on aging to be held in Ann Arbor, July 8-10. Additional information may be obtained from: Wilma Donahue, chairman, Division of Gerontology, University of Michigan, 1510 Rackham Bldg., Ann Arbor, Mich.

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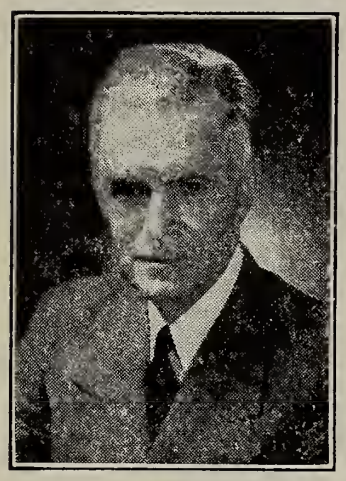
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In Memoriam . . .

J. Craig Bowman, M. D., Upper Sandusky; Rush Medical College, University of Chicago, 1912; aged 65; died May 6; member of the Ohio State Medical Association; member of the American Medical Association; president of the Wyandot County Medical Society, 1945; its secretary-treasurer, 1930-1932; delegate of the local Society to the Ohio State Medical Association for more than 30 years; member of a number of County Society committees. Dr. Bowman began his practice in Upper Sandusky upon completion of his medical training and had been there approximately 40 years. In addition to his practice, he had been a tireless worker in medical organization and in community affairs. During World War I, he served with the Medical Corps and later attained the rank of major in the Medical Reserve Corps. Dr. Bowman was first elected to The Council of the Ohio State Medical Association in 1946 and served until 1950. Previously, in 1944 he had been named chairman of the General Practitioners' Section to the American Medical Association. During his stay on The Council he was active in a number of State Association committees, among them the committee on Medical Economics and the Committee on Workmen's Compensation. He was for several years a member of the board of directors of Ohio Medical Indemnity. Dr. Bowman pioneered in work which led to erection of the Wyandot Memorial Hospital in Upper Sandusky and later was named chairman of its board of directors. He was active also in other community affairs; was a member of several Masonic orders including the Temple and Shrine and a member of the Presbyterian Church. Surviving are his widow, a son, a daughter, a brother and two sisters.



J. C. BOWMAN, M. D.

Henry Noble Crandall, M. D., Springfield, Pa.; George Washington University School of Medicine, 1904; aged 75; died April 13; former member of the Ohio State Medical Association, last in 1947; secretary-treasurer of the Ashtabula County Medical Society, 1941. Dr. Crandall was a practicing physician in Conneaut from 1917 until his retirement in 1946. A member of the Army Medical Corps during World War I, he was a member of the American Legion. Other affiliations included memberships in the Methodist Church and the Masonic Lodge. Surviving are his widow; a son, Dr. Noble F. Crandall, Jamestown, N. Y.; a daughter; two brothers; and two sisters.

Ralph P. Daniells, M. D., Toledo; Rush Medical College, University of Chicago, 1899; aged 78; died April 19; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Daniells had served approximately 48 years of his professional career in Toledo, and had been presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was active in numerous civic and fraternal organizations among which were the Rotary Club, the Photographic Society of America, the Camera Club of Toledo and several Masonic orders. He also was a member of the Episcopal Church. Surviving are his widow, a daughter, a son and a brother.

Joseph A. Eisenberg, M. D., Dayton; Marquette University School of Medicine, 1933; aged 44; died April 29; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Eisenberg practiced for approximately 12 years in Dayton. During World War II, he had served with Army Medical Corps and had attained the rank of major. He was a member of the Temple. Surviving are his widow, two daughters, two sons, a sister and a brother.

Joseph L. Fetterman, M. D., Cleveland; Western Reserve University School of Medicine, 1921; aged 56; died April 12; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Psychiatry and Neurology; Fellow of the American Psychiatric Association, member of the Association for Research in Nervous and Mental Diseases, the Central Neuropsychiatric Association and other professional societies. A past-president of the Academy of Medicine of Cleveland and former member of its Board of Directors, Dr. Fetterman served on numerous committees for his society and was at one time a delegate to the Ohio State Medical Association. Dr. Fetterman turned to his specialty virtually from the beginning of his practice. On the staff of Lakeside Hospital from 1923, he successively held positions as neurologist at the outpatient department, assistant visiting neurologist and assistant clinical professor of nervous and mental disease. From 1947, he devoted his time to his private practice and directorship of the Fetterman Clinic. When ill health terminated Dr. Fetterman's military service during World War II, he was executive officer at the School of Military Psychiatry at Brentwood, Long Island. A medical writer from his early practice, Dr. Fetterman was the author of more than 79 published professional articles and three books. He was a member of the Temple. Surviving are

his widow, two sons, a daughter, his mother, two brothers and two sisters.

Earl D. Foltz, M. D., North Baltimore; Western Reserve University College of Medicine, 1919; aged 61; died April 10; member of the Ohio State Medical Association; member of the American Medical Association; president of the Wood County Medical Society, 1927-1928, delegate for a number of terms and member of several local committees. A native of North Baltimore, Dr. Foltz served all of his professional career there. Affiliations included memberships in the local Chamber of Commerce, the American Legion, and the Evangelical-United Brethren Church. Surviving are his widow, a son, a daughter, and two sisters.

Raymond H. George, Sr., M. D., Cincinnati; Loyola University School of Medicine, 1916; aged 66; died April 19; Dr. George had been a physician at the regional office of the Veterans Administration in Cincinnati since 1946. He had previously been with the V. A. center in Dayton. After serving with the British Army during World War I, Dr. George went into private practice in Illinois. In 1929 he became associated with the Veterans Administration. From 1934 to 1946 he was with the V. A. Center in Dayton. He transferred to Cincinnati in 1946. Survivors include his widow, three sons, two brothers and two sisters.

Barton L. Good, M. D., Van Wert; Hahnemann Medical College, 1904; aged 76; died April 16; member of the Ohio State Medical Association; member of the American Medical Association; secretary-treasurer of the Van Wert County Medical Society, 1918, and its president, 1935-1936; also active as member or chairman of a number of county society committees; member of the American Roentgenology Society. A native of that vicinity, Dr. Good returned to Van Wert to practice shortly after completion of his medical education. During World War I, Dr. Good served with the Army Medical Corps overseas. He belonged to the Methodist Church, the Masonic Lodge, the American Legion and was a charter member of the local Rotary Club. Surviving are two sons, one of whom is Dr. Roland H. Good, also of Van Wert, and a brother.

Walter Lee Kline, M. D., Cherry Chase, Md.; Columbia University College of Physicians and Surgeons, 1898; aged 81; died April 5. Dr. Kline served two terms as Montgomery County coroner from 1903 to 1907. His career after he left Ohio included considerable service with the Army and with the Veterans Administration. Surviving are two sons, Dr. Walter L. Kline, Jr., Messick, Va., and Dr. Philip S. Kline, San Antonio, Texas.

Elwood Miller, M. D., Springfield; Medical College of Ohio, Cincinnati, 1887; aged 88; died April 13; former member of the Ohio State Medical Association, last in 1930. Dr. Miller began his practice in Enon before moving to Springfield in 1907. During World War I, he served with the Medical Corps returning to Springfield after the war. He had been retired for about 10 years. Affiliations included the Masonic Lodge and the Presbyterian Church. Survivors include his widow, and two daughters.

Edwin Waterman Mitchell, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1882; aged 98; died April 20; member of the Ohio State Medical Association; member of the American Medical Association. One of Ohio's oldest physicians at the time of his death, Dr. Mitchell had rounded out 63 years of practice before his retirement in 1945. A pioneer in many phases of early practice and medical organization, Dr. Mitchell was president of the Cincinnati Academy of Medicine in 1899, and was one of the organizers of the Anti-Tuberculosis League in his city. The president of the University of Cincinnati referred to him as an "almost legendary figure in the annals of medicine of the University," so versatile had been his teaching assignments. He was designated professor emeritus of clinical medicine in 1941. Affiliations included Alpha Omega Alpha, Phi Beta Kappa, the Masonic Lodge, Military Order of the Loyal Legion. Survivors include three sons.

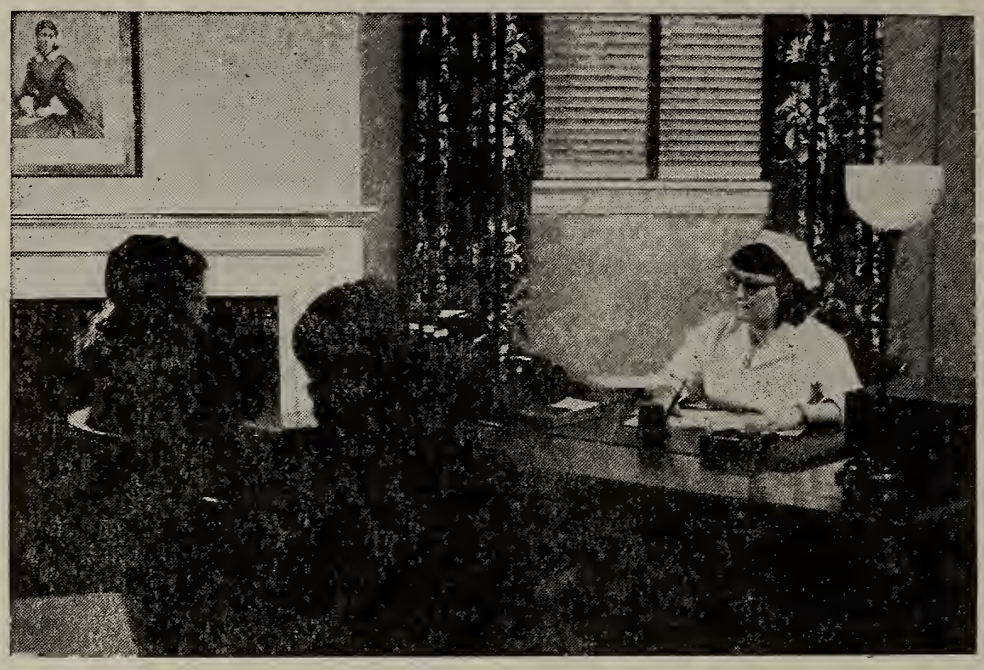
Charles O. Overholser, M. D., Dayton; Ohio State University College of Medicine, 1911; aged 75; died April 18; former member of the Ohio State Medical Association, last in 1947. Dr. Overholser started his practice in West Manchester, moved to Verona and later to Gordon, going to Dayton in 1922. He was a member of the Methodist-Episcopal Church and the Masonic Lodge. Surviving are his widow, two sons, a daughter, a sister and three brothers.

Harry T. Schroer, M. D., Cincinnati (Cheviot); Miami Medical College, Cincinnati, 1902; aged 72; died April 10; Dr. Schroer practiced medicine in the Cheviot area for approximately 50 years. Survivors include his widow, and a brother.

Herbert L. Selo, M. D., Findlay; University of Cologne, Germany, 1923; aged 54; died April 9; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Selo had practiced in Germany before coming to the United States in 1938. He moved to Findlay the following year. He was active in a number of professional societies including the American Academy of General Practice. Surviving are his widow, a daughter, three stepchildren and two sisters.

George W. Stimson, M. D., Warren; University of Pennsylvania School of Medicine, 1903; aged 72; died April 20; former member of the Ohio State Medical Association, last in 1949; diplomate of the American Board of Otolaryngology; mem-

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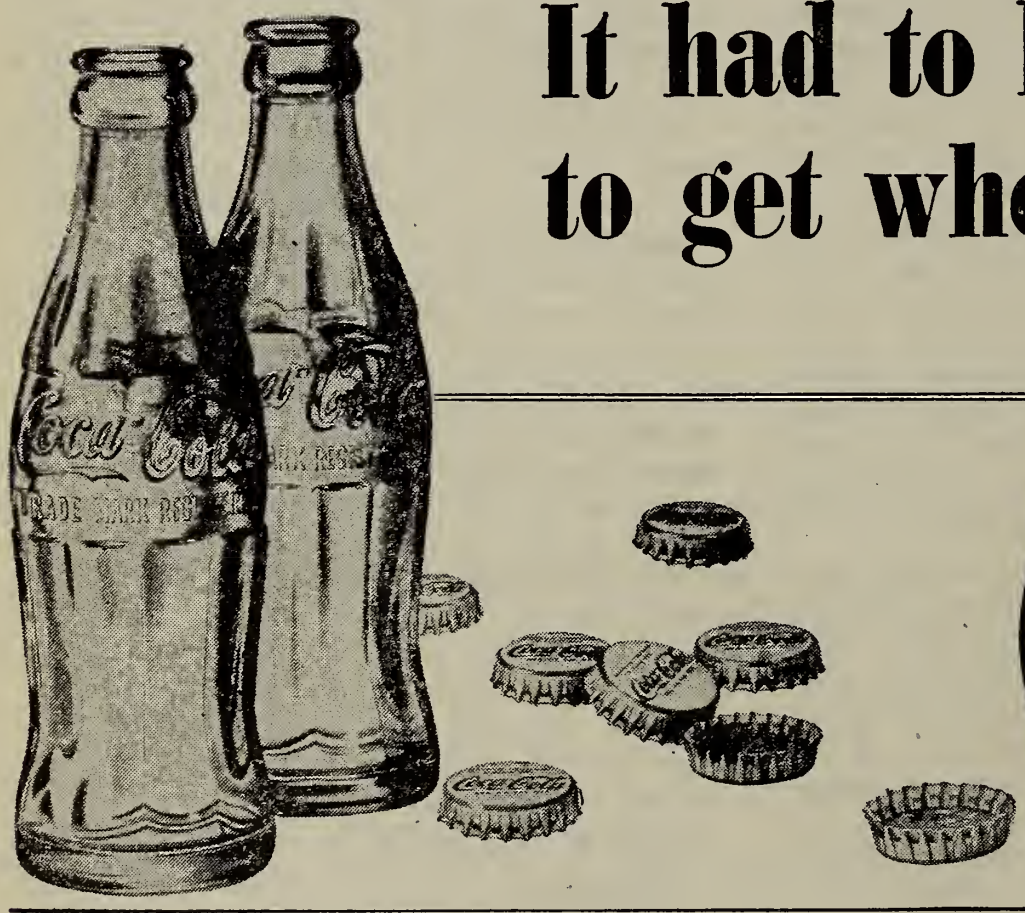
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ber of the American Academy of Ophthalmology and Otolaryngology. A practicing physician for approximately 50 years, Dr. Stimson had served 27 of them in Warren. He formerly practiced in Pittsburgh, Pa. Affiliations included the Buckeye Club, the American Legion and the Episcopal Church. Surviving are two daughters, and a brother.

Thomas J. Talbott, M. D., Lima; Ohio State University College of Medicine, 1943; aged 37; died April 17 in a traffic accident; member of the Ohio State Medical Association and the American Medical Association. Dr. Talbott served with the Army Medical Corps during World War II and upon release went into practice in Lima in association with his father, Dr. J. E. Talbott. From 1948 to 1952 he served as Allen County coroner. His parents and a sister survive.

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

U. S. Public Health Service is asking states to report poliomyelitis cases as paralytic or non-paralytic. According to Dr. C. C. Dauer, of the Office of Vital Statistics, this system would serve as a guide to the Office of Defense Mobilization in allocating gamma globulin for polio.

* * *

Use of body armor by U. S. troops in Korea is helping reduce mortality rate, now under two per cent of all wounded, but is increasing the proportion of non-fatal extremity wounds, now about 70 per cent, according to Dr. Melvin A. Casberg, assistant to the secretary of defense for health and medical affairs. He also noted an increase in head injuries.

* * *

Senator Frear (D.-Del.) has introduced a bill to abolish the Federal old age and survivor's insurance system and turn over the O. S. A. I. trust fund to the states.

* * *

A total of 150 June medical school graduates have been selected for the Army's medical intern program. All will be assigned to Army's 11 teaching hospitals, and will serve as first lieutenants in the reserve.

* * *

Arthur J. Altmeyer, Commissioner of Social Security, has retired after seven years in that position. For more than 15 years he has influenced social security legislation and programs. Under the new Department of Health, Education and Welfare, this position becomes a presidential appointment.

* * *

Of 12,527 physicians coming into the three military services since the start of the Korean war, only six have been denied commissions on grounds of questionable loyalty. The ratio for dentists is about the same, three out of 5,409. Although 42 physicians and dentists have been inducted as privates during the period, 31 were subsequently commissioned or discharged for physical disability.

Dr. Albert M. Snell, of Palo Alto, California, is new chairman of the Veterans Administration Council of Chief Consultants, succeeding Dr. Ralph M. Tovell, who remains on the Council. Also reappointed to the Council are Drs. Harold G. Scheie, John N. Robinson, Bernard J. Pisani, and Norton Canfield.

* * *

Unless Congress rejects a reorganization plan pending at this time, the Defense Department will create the position of Assistant Secretary for Health and Medical matters, to be filled by presidential nomination. The A. M. A. has urged that such a position be created in an effort to "insure a more equitable utilization of medical manpower by the armed services."

* * *

Frederick H. Schmidt of Silver Spring, Maryland, is the new Security Officer for the Department of Health, Education, and Welfare. He spent the past 18 years in investigative work, including service with the State of Ohio and the Federal Bureau of Investigation.

* * *

Newly appointed chief of clinical research at the National Institute of Neurological Diseases and Blindness is Dr. G. Milton Shy, who comes to Federal service from the faculty of the University of Colorado.

* * *

As part of the government economy program, the expensive engraved tax stamp issued to physicians, pharmacists and other handlers of narcotics will give way in July to a cheap printed stamp.

* * *

A bill has been introduced in the Senate to drop references to "Aureomycin" in Federal Food and Drug Act and substitute the chemical name, "Chlortetracycline." A companion bill to H. R. 5016 in the House, enactment would simplify the task of Lederle in obtaining registration of "Aureomycin" as a trade name.



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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

ADAMS

The Adams County Medical Society held its regular meeting on April 16 in the staff room of the Adams County Hospital. The speaker was Dr. Roy S. Kile, Cincinnati, who spoke on "Newer Methods of Therapy in Dermatology."

HAMILTON

Two nationally known physicians from other states were guest speakers at meetings of the Academy of Medicine of Cincinnati during May.

On May 5 Dr. Arthur C. Curtis, professor of dermatology and syphilology, University of Michigan Medical School, spoke on the subject, "Cutaneous Manifestations of Systemic Disease."

On May 19, Dr. Paul White, clinical professor of medicine, Harvard University Medical School, spoke on the subject, "Personal Experiences in Cardiology."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

CLARK

"The Doctor as a Medical Witness" was the subject discussed at the April 13 meeting of the Clark County Medical Society held in the Bancroft Hotel. Guest speakers for the occasion were Judge Golden C. Davis and Attorneys John Cole, George Schwer and Bitner Browne.

At the May 18 meeting of the Society, the subject, "Jaundice," was discussed by a panel, with Dr. John F. Harley acting as moderator.

DARKE

Dr. P. K. Champion, Dayton, spoke on the subject, "Sterility Problems," at the April 28 meeting of the Darke County Medical Society in Greenville.

At the May 19 meeting of the Society, Dr. Joseph Morton, professor of radiology, Ohio State University College of Medicine, spoke on the subject, "Extra-Gastrointestinal Pathology."

GREENE

Dr. Harry King, Dayton, discussed ACTH and Cortisone at the May 14 meeting of the Greene County Medical Society in Xenia.

MIAMI

Dr. George A. Woodhouse, Pleasant Hill, who has completed 25 years as secretary of the Miami County Medical Society, was honored at a testimonial dinner at the Troy Country Club. Mr. Charles S. Nelson, Columbus, Executive-Secretary of the Ohio State Medical Association, was feature speaker for the occasion. He referred to the many responsibilities Dr. Woodhouse has undertaken in behalf of organized medicine culminating in his recent election to The Council of the State Association. A delegate to the American Medical Association, Dr. Woodhouse headed the committee which sponsored Dr. Edward McCormick, Toledo, as President-Elect of the A.M.A.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

Dr. Maxwell M. Wintrobe, professor of medicine, Utah School of Medicine, and author of a widely used book on hematology, has been announced as guest speaker for the Inter-Hospital Postgraduate Lecture Series to be presented on June 9 and 10 by the Medical Advancement Trust and the Maumee Valley Hospital.

His theme will be Diseases of the Blood. The following program has been announced:

Tuesday, June 9—Noon, "The Development of Knowledge Concerning the Anemias"; 4:30 p. m., "The Pathogenesis of Various Types of Anemia"; 8:00 p. m., "The Diagnosis and Treatment of Anemias."

Wednesday, June 10—Noon, "Disorders of the Spleen and the Physiological Basis and Indications for Splenectomy"; 4:30 p. m., "The Nature and Manifestations of Leukemia and Allied Disorders"; 8 p. m., "The Management of Leukemia and Allied Disorders."

All lectures will be at the Academy of Medicine Building, 3101 Collingwood Blvd., Toledo.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

An historical program was held at the May 15 meeting of the Academy of Medicine of Cleveland in the Medical Library Auditorium.

Mr. H. Van Y. Caldwell, executive secretary of the Academy, spoke on the subject, "Thirty Years of the Academy."

Dr. Charles L. Hudson, president, spoke on "The Academy This Year."

Additional regular monthly meetings were conducted by the several sections of the Academy.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

The Physician's Responsibility to This Community was the theme discussed in an open dis-

cussion by all members on April 28 at the Elks Club.

The annual golf meet was held at the Youngstown Country Club on May 14. Physicians enjoyed the tournament, program and dinner as guests of Charles Pfizer & Company, pharmaceutical firm.

STARK

Dr. George S. Hackett, spoke on the subject, "Sacroiliac Sprain" at the April meeting of the Stark County Medical Society in Canton.

Dr. C. A. Gustafson, Youngstown, Councilor of the Sixth District of the Association, reported on pending legislation and on other matters acted upon by The Council at its last meeting.

Dr. William Skipp, Youngstown, delegate to the A. M. A., gave a report on the recent Washington meeting of the A. M. A. House of Delegates.

SUMMIT

Charles Baxter Burbank, assistant in surgery, Harvard Medical School, and assistant in surgery, Massachusetts General Hospital, spoke on the subject, "Treatment of the Injured Hand," at the May 5 meeting of the Summit County Medical Society at the University of Akron.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Members of the Belmont County Medical Society, at the May 21 meeting, heard a discussion on the subject, "Pneumonoconiosis," with Dr. H. H. Cashman describing case reports, and Dr. H. G. Little discussing the pathology.

TUSCARAWAS

Dr. Joseph J. Brumbaugh, Canton, spoke on the subject, "The Psychological Preparation for Labor," at the May 14 meeting of the Tuscarawas County Medical Society in Dover.

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

ATHENS

Dr. Warren V. Sprague, Chauncey, was honored at a meeting of the Athens County Medical Society on May 12 in the Sheltering Arms Hospital, Athens. He was presented the 50-Year Pin and Certificate of the Ohio State Medical Association by Dr. R. S. Martin, Zanesville, Councilor of the Eighth District.

GUERNSEY

The Guernsey County Medical Society voted unanimously at its regular meeting in April to go on record as being very much opposed to the investigation at the Cambridge State Hospital and to the unfair notoriety which it has caused. "We

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POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, two weeks, starting June 15, July 6, August 3. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting Aug. 3. Surgical Anatomy & Clinical Surgery, two weeks, starting June 15, Aug. 17. Fractures & Traumatic Surgery, two weeks, starting June 15. Esophageal Surgery, one week, starting June 22. Breast & Thyroid Surgery, one week, starting June 22. Gallbladder Surgery, ten hours, starting June 29. Surgery of Colon & Rectum, one week, starting Sept. 21. Basic Principles in General Surgery, two weeks, starting Sept. 21. General Surgery, one week, starting Oct. 5. General Surgery, two weeks, starting Oct. 12. Thoracic Surgery, one week, starting Oct. 12.

GYNECOLOGY—Intensive Course, two weeks, starting June 15, Sept. 21. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 14.

OBSTETRICS—Intensive Course, two weeks, starting Oct. 5.

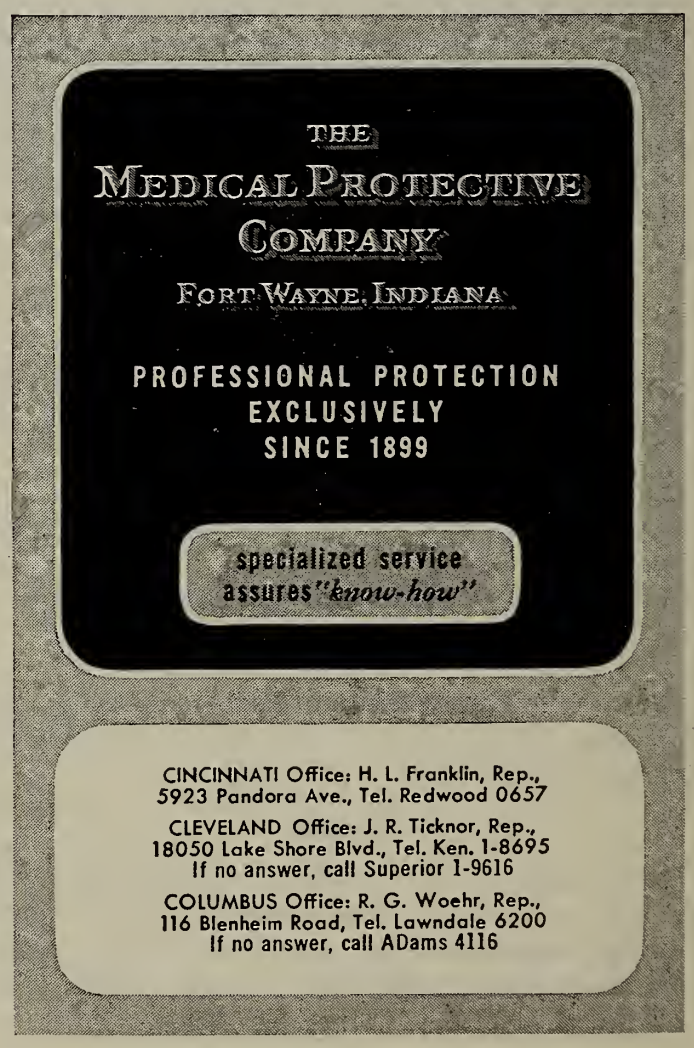
MEDICINE—Intensive General Course, two weeks, starting Oct. 12. Electrocardiography & Heart Disease, two weeks, starting July 13. Allergy, one month and six months, by appointment.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 28.

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feel that an irreparable injustice has been done to Dr. Arthur Hopwood, superintendent of Cambridge Hospital, who is very highly respected in this community, not only for the great work which he is doing as a doctor, but for his own fine character," the society resolved.—Reo M. Swan, M. D., secretary-treasurer.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. Norman O. Rothermich, Ohio State University College of Medicine, spoke on the subject, "Intra-Articular Hydrocortisone Indications and Usage," at the May 11 meeting of the Scioto County Medical Society.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Dr. Rupert B. Turnbull, Cleveland Clinic, was guest speaker at the May 18 meeting of the Columbus Academy of Medicine at the Columbus Gallery of Fine Arts. His subject was "The Surgical Treatment of Ulcerative Colitis," and was illustrated by a color movie on the subject, "Colectomy with Ileostomy for Ulcerative Colitis."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

"Treatment of Diseases of the Thyroid Gland" was the subject discussed by Dr. George Crile, Jr., Cleveland, at the April 14 meeting of the Lorain County Medical Society in Lorain.

The Society held its yearly postgraduate meeting on May 13 at the Spring Valley Country Club. Dr. L. H. Trufant, secretary, reported a very successful meeting with 80 members attending.

The program was as follows, the visiting lecture team being from the University of Pittsburgh:

"Management of Varicose Veins," by Dr. Samuel P. Harbison, professor and chairman of the Department of Surgery, University of Pittsburgh School of Medicine.

"Geriatrics—What Can Be Done To Prevent Arteriosclerosis," by Dr. Campbell Moses, director of Addison Gibson Laboratory and associate professor of medicine.

"Management of Psychosomatic Disorders by the General Practitioner," by Dr. James T. McLaughlin, associate professor of psychiatry.

"Diagnosis and Treatment of Ectopic Pregnancy," by Dr. Charles J. Barone, professor of obstetrics, and medical director of the Magee Hospital.

"Use of Gamma Globulin in Poliomyelitis," by Dr. W. McD. Hammon, professor of epidemiology and microbiology, Graduate School of Public Health.

Round table discussions and an evening dinner were part of the program.

RICHLAND

The regular meeting of the Richland County Medical Society was held at the Mansfield General Hospital on April 16. Dinner was served, after which a business meeting was held.

A panel discussion concerning Pulmonary Diseases was presented by three doctors from Ohio State University College of Medicine—Drs. John Prior, Karl Klassen and Robert Atwell.—H. G. Knierim, M. D., secretary.

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Activities of Woman's Auxiliary . . .

By MRS. EDWARD L. VOKE, Chairman, Publicity Committee, 243 Hampshire Road, Akron 13, Ohio

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President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House

Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima

Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

A. M. E. F. FUND

Mrs. George W. Cooperrider, Columbus, chairman of the American Medical Education Foundation Committee for the Auxiliary, announced the following additional contributions to the fund: (1) Check from Erie County; (2) Check from Muskingum County; (3) 2nd contribution from Montgomery County; (4) $5.00 contribution from anonymous Hamilton County member; (5) $25.00 saved from flower fund during convention by using paper orchids; (6) $25.00 from Mrs. Paul Woodward (her presidential gift). (7) Check from Ashtabula County. Final report (May 21)—45 counties; Total, $2,441.00.

AUGLAIZE

At the April meeting of the Auglaize County Auxiliary *Off the Record* was reviewed by Mrs. Earl Kent of Wapakoneta. This was a collection of the best stories of foreign correspondents, collected by the Overseas Press Club of America. The new officers elected at this meeting were: Mrs. David Nielsen, Waynesfield, president; Mrs. T. H. Will, vice-president; Mrs. Clyde Berry, Wapakoneta, Secretary-Treasurer. The wives of the County Dentists were guests.

BUTLER

The Butler County Auxiliary was highly honored at the State Medical Auxiliary meeting in Cincinnati when it was selected by the State Credits and Awards Committee as the auxiliary with the greatest record of achievement for the year. The award is based on activities, program, philanthropies and public relations. The group was honored further when its president, Mrs. G. E. Marr was nominated as state delegate to the National Convention in New York City in June.

On April 17, the Auxiliary assisted the Auxiliary of Chuck Cain Post 7670, Veterans of Foreign Wars, in the annual fund campaign of the Hamilton unit of the Cancer Society. On April 28, Mrs. Paul Ivins, chairman of the Nurse Recruitment Committee, presented Miss Johanna Vogel, R. R. 2, Oxford, with the Esther Brosius Award in the recent essay contest sponsored by the Auxiliary.

CUYAHOGA

On April 15, Mrs. Charles A. Obert was elected President of the Cuyahoga County Auxiliary, succeeding Mrs. Charles A. Higley. Mrs. Obert was State Legislation Chairman last year and will continue in the same position this coming year. Officers elected with her, include: Mrs. Henry J. John, president-elect; Mrs. Christopher A. Colombi, vice-president; Mrs. Spencer Braden, recording secretary; Mrs. S. N. DeVille, corresponding secretary, and Mrs. David V. Rosenberg, treasurer.

Directors elected are: Mrs. J. L. Bilton, Mrs. William L. Huffman, Mrs. John Budd, Mrs. Edward M. Kline, Mrs. Bernard Larsen, and Mrs. H. S. Van Ordstrand. Special Committee chairmen are Mrs. R. J. McCaffery, Hospitality; Mrs. A. V. Boysen, nurses' award; Mrs. Burdette Wylie, program; Mrs. Allen E. Walker, public relations; Mrs. John J. McCarthy, membership; and Mrs. E. J. Humel, assistant treasurer.

DELAWARE

Thirty high school girls attended a tea given by the Delaware County Auxiliary. Miss Mil-

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California State Personnel Board

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dred Newton, director of Ohio State University School of Nursing, talked on selecting a school of nursing, and Mrs. Dorothy Rayce, tri-county public health nursing supervisor, showed the film, "Women in White."

At the regular meeting following the tea, Mrs. Edward Jenkins was elected president for the coming year. Mrs. James Parker will serve as president-elect; Mrs. George Parker as vice-president; Mrs. Chester Theiss, secretary; and Mrs. F. M. Stratton, treasurer.

ERIE

The Silver Chalice, by Thomas Costain, was reviewed by Mrs. Karl Kinderle at the May meeting of the Erie County Auxiliary. Newly elected officers were installed by Mrs. E. J. Meckstroth. Mrs. A. G. Groscost turned the gavel over to Mrs. L. G. Parker, newly elected president.

It was announced that the Auxiliary would assist the staff of the Good Samaritan Hospital during its "Open House" on May 12.

FRANKLIN

"Put on Your Old Spring Bonnet with a New Ribbon on It" was the theme of the program presented by Mrs. George Mandel, who talked on hat making at the April meeting of the Franklin County Auxiliary. The program was arranged by Mrs. Robert J. Henry.

KNOX

Mrs. Henry T. Lapp, president; Mrs. Gordon Pumphrey, president-elect; Mrs. Joseph Allman, vice-president; and Mrs. Delbert Schmidt, Secy.-Treas., were the new officers elected at the closing meeting of the Knox County Auxiliary.

The members of the Auxiliary served as hostesses during the annual Open House at Mercy Hospital.

LICKING

Mrs. Carl Petersilge was elected as the new president of the Licking County Auxiliary. The other officers elected to serve with her were Mrs. Edwin C. Lane, president-elect; Mrs. Ralph E. Pickett, vice-president; Mrs. Norris M. Burleson, secretary; and Mrs. George H. Gressle, treasurer.

Members of the Auxiliary provided transportation for sixty-four future nurses from Newark and Licking Counties to attend the Career Day program at Ohio State University. The event, which is sponsored by the O. S. U. School of Nursing, featured tours of the new medical center.

Miss Gloria Lee Oliver was chosen to receive the annual scholarship in nursing, awarded by the Auxiliary. The annual nurse scholarship given by the Medical Society, was awarded to Miss

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Mary Elizabeth Smith, the alternate chosen by the Auxiliary.

LORAIN

The Lorain County Auxiliary entertained one hundred and fifty juniors from 21 high schools at its annual nurse recruitment program.

The speakers were: Sister M. Edith, director of nursing of the St. John's College, Cleveland; Miss Anne Deed, Director of Nursing of Western Reserve University; and Miss Margaret Krapp of Elyria Memorial Hospital.

LUCAS

At the luncheon meeting of the Lucas County Auxiliary in the Academy Building in April, Mr. Martin A. Janis, president of the Zoo Board, spoke on "Our Toledo Zoo."

On April 18, the Auxiliary sponsored a Gala Western party limited to members and their husbands.

The Live Issues of Today Study Group (afternoon) met May 6 at the home of Mrs. Howard Parkhurst. The evening group met at the home of Mrs. R. P. Whitehead, Jr. The subject of both meetings was "South America-Good Neighbor Policy."

The mental hygiene group met April 28 at the home of Mrs. Henry Hartman and discussed Geriatrics.

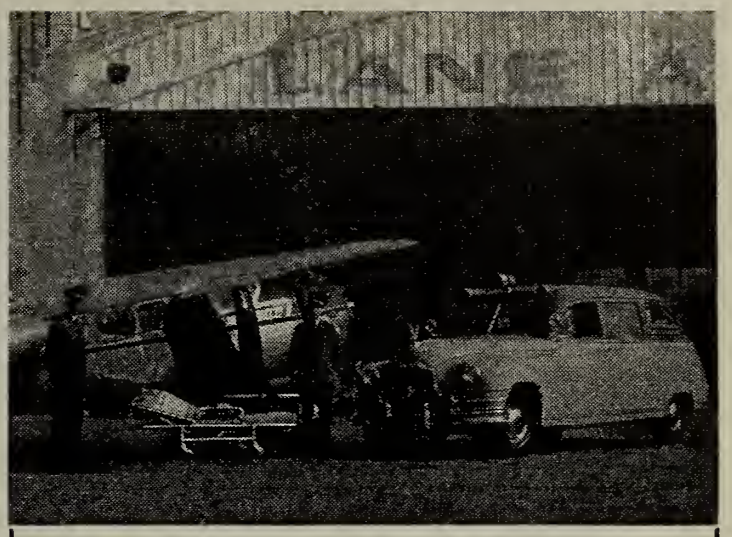
OTTAWA

There were 84 sophomore girls from Port Clinton, Oak Harbor, Lakeside, and Elmore High Schools entertained at the annual nurse recruitment tea given by the Ottawa County Auxiliary. They were taken on a tour of the local hospital and served punch and cookies afterward in the Nurses Home.

RICHLAND

Mrs. P. A. Blackstone became the 14th president of the Richland County Auxiliary when she received the gavel from Mrs. Albert Voegele, the retiring president.

Mr. Donald Owens, safety director of the Red Cross, who was introduced by Dr. Robert Mof-



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fatt, presented the film "Pattern for Survival" as the program for the May meeting.

This Auxiliary was honored at the State Convention by having Mrs. R. Donald Campbell named director of District 11 and Mrs. C. H. Bell, State Program Chairman.

STARK

Mrs. Homer Keck, retiring president of the Stark County Auxiliary, turned over the gavel to Mrs. A. A. Fisher at the April meeting. Elected to serve with Mrs. Fisher were: Mrs. Herbert Jones, president-elect; Mrs. J. Sharp Wilson, vice-president; Mrs. Clarence V. Smith, recording secretary; Mrs. Raymond Saxen, corresponding secretary; and Mrs. Cleon Couch and Mrs. L. B. Schumaker, assistant treasurers.

The program featured a musicale; Mrs. William Slasor and Mrs. C. S. Palmer were in charge of arrangements.

SUMMIT

At the annual May meeting, Mrs. Norman E. Wentsler received the gavel from Mrs. Edward L. Voke, retiring president. The other new officers were Mrs. Arthur Dobkin, president-elect; Mrs. Edward R. Blower, vice-president; Mrs. James R. Lemmon, recording secretary; Mrs. Thomas Brownell, corresponding secretary; and Mrs. R. B. Smith, treasurer.

Mrs. Charles Baxter Burbank, the wife of the Medical Society's speaker for the evening, was a guest at the meeting.

Annual reports were given. It was announced that Mrs. Edward L. Voke had been made State Publicity Chairman at the State Convention.

Dr. E. Perry McCullagh, head of the Department of Endocrinology at Cleveland Clinic, sailed late in April for Europe where he was scheduled to address joint meeting of the Royal Danish Medical Society and the Royal Danish Endocrine Society in Copenhagen on the subject of male endocrinology, and to lecture on diabetes control at a meeting of the faculty members and advanced students of the University of Leyden.

Dr. William M. Skipp, Youngstown, presented a paper on "Thyroidectomy, Indications and Pitfalls," at the May 5-6 meeting of the Great Lakes Division, U. S. Chapter, International College of Surgeons meeting in Chicago.

The Veterans Administration has announced an increase of one-half per cent in the maximum allowable interest rate on GI loans guaranteed by V. A. This action raised the rate from 4 to 4½ per cent.

Oscar C. Pogge, director of old age and survivors insurance, and for 17 years a staff member of Social Security Administration, has resigned.

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Institute on Soil, Food and Health To Be Held in Chicago, July 1-3

The program of the 12th annual Institute on Soil, Food and Health has been arranged by Dr. Jonathan Forman, Editor of *The Journal* and President of Friends of the Land, to be held at the medical center of the University of Illinois, Chicago, on July 1, 2 and 3.

The theme of the program is this: After asking a geologist, an ecologist, a philosopher and an economist to look at the problems of the conservation of our natural resources, a group of some 14 scientists from many special fields will explore the future possibilities of the race getting an adequate supply of food, feed and fiber. This represents a completely ecologic approach to such questions as population pressure and the future health of the peoples of the world.

These institutes have the endorsement of the Nutrition Committee of the Illinois State Medical Society. The discussions are to be in popular language and the public is most welcome to attend.

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GENERAL PRACTITIONER WANTED as replacement while doctor is in service; practice in small town in Southwest Ohio. Partnership with established physician; small Obstetrical Hospital in connection with offices; needed by July 1. Box 738, c/o Ohio State Medical Journal.

WANTED young draft-exempt physician to share office of busy general practitioner; no investment required; just need help. Prefer GP or interested in Internal Medicine. Located North-Central Ohio, 50,000 community. Partnership could be arranged after trial. Box 737, c/o Ohio State Medical Journal.

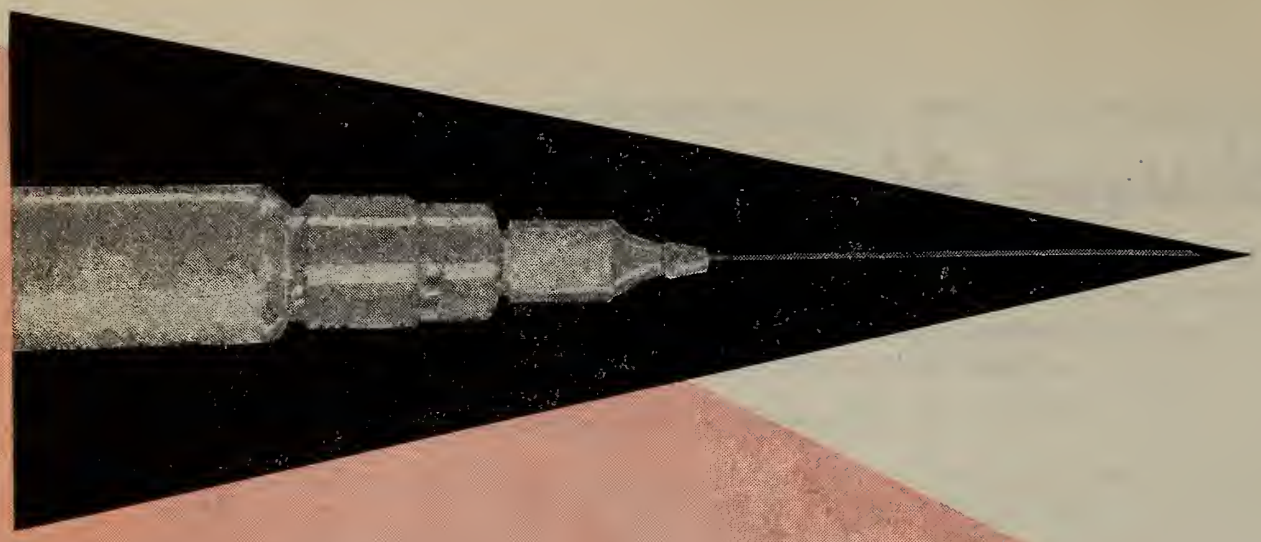
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Dr. Jonathan Forman, Editor of *The Journal*, has been named a member of the Board of Trustees of the American Foundation for Research in Allergy, a foundation sponsored by both national allergy societies.

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If the concept of an ideal dietary supplement could be formulated, it might well be one that provides qualitatively every substance of moment in human nutrition. It would provide those for which human daily needs are established as well as others which are considered of value, though their roles and quantitative requirements remain unknown.

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Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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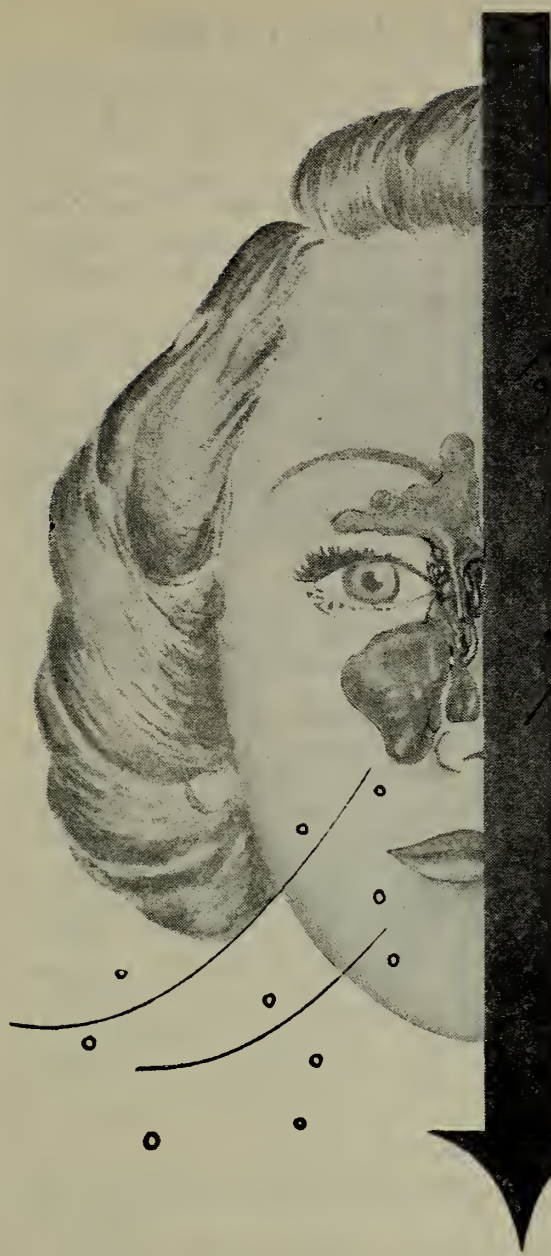
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1. Von Alyea, O. E., and Donnelly, Allen: *Arch. Otoloryng.*, 49:234, Feb., 1949.

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2 *to relieve symptoms*



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The Fifth Year of Aureomycin, by *Lederle Laboratories Division, American Cyanamid Co., 30 Rockefeller Plaza, New York 20, N. Y.* Apply. It presents, in some 400 pages, a summary of Medicine's experience with this valuable antibiotic.

Gynecologic and Obstetric Pathology, with Clinical and Endocrine Relations, by Emil Novak, M. D., ($10.00. Third Edition. *W. B. Saunders Co., Philadelphia 5, Penna.),* presents a revamping of this whole book in keeping with progress in the field. It revises and recrystallizes such subjects as carcinoma of the cervix, carcinoma *in situ,* hydatidiform moles, and chorioepithelioma, as well as certain of the ovarian tissues. At the same time it incorporates all of the new developments, since the last edition.

Divine Healing—Special issue on Divine Healing of **The Christian Ministry,** John R. Mumaw, editor. ($0.25. *Mennonite Publishing House, 610-616 Walnut Ave., Scottdale, Penna.).* An exposition by *The Mennonite Press* of Miracles, Signs and Wonders—a sane approach to the subject recognizing that Christ recognizes our infirmities, and they may be used for our spiritual development while having an understanding for those who say His atonement has made provision for the cure of all manner of diseases.

Disorders of the Circulatory System, edited by Robert L. Craig, M. D., ($5.50. *MacMillan Company, New York 11, N. Y.),* presents a symposium given at the 24th Graduate Fortnight of The New York Academy of Medicine. The subjects treated are: Role of Connective Tissue: Contraction of Heart Muscle Fiber; Lipid Metabolism and Arteriosclerosis; Diet and Lipotropic Agents; Coronary Disease, its recognition; Importance of Arrhythmias; Pathologic Physiology of Mitral Stenosis; Surgery of Acquired Valvular Disease; Surgical Management of Congenital Heart Disease; EKG Effects of Myocardial and Pericardial Injury; Edema and Dyspnea; Mechanism of Circulatory Failures; Treatment of Some Bacterial Infections.

Practice of Psychiatry, by William S. Sadler, M. D., ($15.00. *The C. V. Mosby Co., St. Louis, Mo.),* is an endeavor to place before the general practitioners of medicine the problems of maladjustments of the personality, preneurotic disorders and the psychoses by one of the popular writers in the field.

Principles and Practice of Anesthesiology, by Vincent J. Collins, M. D., ($10.00. *Lea & Febiger, Philadelphia 6, Penna.).* No better illustration of the speed by which this subject has become an independent discipline than this volume of 526 pages. All of the great strides that have been made in both the art and science of controlling pain and providing the best conditions for the operating surgeons to accomplish their different tasks are adequately described.

American Pocket Medical Dictionary, (19th Edition, $3.25 plain; with thumb index, $3.75. *W. B. Saunders Company, Philadelphia 5, Pa.),* has served well these 55 years those who have needed a dictionary of the principal terms used in medicine, nursing, pharmacy, dentistry, veterinary science and allied biological subjects.

The Hair and Scalp—A Clinical Study with a Chapter on Hirsuties, by Agnes Savill, M. D., ($5.50. 4th Edition. *Williams & Wilkins Company, Baltimore 2, Md.).* The author is a woman physician with an extensive experience in medicine and medical writing. She has incorporated into this book all that is of value from older treatises on the hair, including the extensive observations of Sabouraud, under whom she studied. She has correlated these data with the newest observations, many of which are her own.

Illustrated Guide to Sex Happiness in Marriage, by Lucia Radl, M. D., ($1.75. *Greenberg Publisher, Inc., New York 22, N. Y.),* is a sincere attempt to attack the obvious and persistent ignorance about sex. Your reviewer still insists that all of the list of problems on which the author attempts to throw light will never be solved until the male's education on the whole subject begins earlier and motivates him to congress for procreation only. The female will accept little less.

Gastrointestinal X-Ray Diagnosis, by Max Ritvo, M. D., and I. A. Shauffer, M. D., ($20.00. *Lea & Febiger, Philadelphia 6, Penna.),* describes the lesions of the gastrointestinal tract and its related viscera which can be diagnosed by roentgen examination. While its technical aspects and the clinical consideration are adequately discussed, the main emphasis is on its description, discussion and evaluation of the roentgen manifestations on the basis of which the diagnosis can be established.

Nerve Impulse—Transactions of The Third Conference, Edited by H. Houston Merritt, M. D., ($3.50. *Josiah Macy, Jr. Foundation, New York 36, N. Y.),* is another one of the attempts of this Foundation to solve the problem of communication between disciplines. In this report, I. B. Wilson leads the discussion on "Biochemical Similarities and Differences between Synaptic

Transmission and Axonal Conduction"; T. H. Bullock, "Electrical Similarities and Differences between Synaptic Transmission and Axonal Conduction"; J. Z. Young, "The Structure of Synaptic Junction."

Psychiatric Nursing, A Syllabus and Workbook for Student Nurses, by Lenore Kimball, B. S., R. N., (paper $3.75. *C. V. Mosby Company, St. Louis 3, Mo.)*, is designed to aid the student nurse to recognize nursing problems, to evaluate mental and emotional reactions and to organize methods of approach to nursing situations.

The Mentally Retarded Child, by Abraham Levinson, M. D., ($2.75. *The John Day Co., 210 Madison Avenue, New York 16, N. Y.)*, meets a long-felt need for parents of a retarded child. The author, professor of Pediatrics at Northwestern, out of long experience has met the need with this little manual. It gives all the details necessary for the parent to make the adjustment to this rather hopeless situation.

Clinical Electrocardiography in Children, by Gertrude H. B. Nicolson, M. D., ($3.25. *The Macmillan Company, New York 1, N. Y.)*. Although varying in detail according to the individual case, the average child's electrocardiogram follows a simple pattern which may be recognized as that of a normal child rather through its lack of abnormal signs than by the presence of a definite form. The book is replete with illustrations drawn from selected children.

You and Tuberculosis, by James E. Perkins, M. D., and Floyd M. Feldmann, M. D., ($2.50. *Alfred A. Knopf, Inc., New York 22, N. Y.)*, is a popular treatise on patient cooperation and everything he needs to know about his disease, by the Managing Director of the National Tuberculosis Association and his assistant.

Encyclopedia of Aberrations, Edited by Edward Podolsky, M. D., ($10.00. *The Philosophical Library, Inc., New York 16, N. Y.)*, is a systematic exposition of human aberrational behavior written for the intelligent layman as well as the expert in interpersonal relationship. The book treats of all types of aberrations with particular emphasis on the dynamics.

Man's Foods, by Lloyd B. Jensen, Ph. D., ($4.50. *The Garrard Press, Champaign, Ill.)*, tells the story of how Man evolved from a food gatherer to a food producer; how he chose, rejected, tried to reshape Nature to his will in a continuous effort to provide himself with enough of the right kind of food and how, in this long evolution, Man himself changed too—because of, or in spite of, the foods he ate.

The Physical Examination of The Surgical Patient, by J. Englebert Dunphy, M. D., and Thomas W. Botsford, M. D., ($7.50. *W. B. Saunders Co., Philadelphia 5, Penna.)*. In contrast to current trends toward dependence on gadgets and chemical tests, this book teaches the elementary principles of physical examination, for which there is no real substitute.

Microbiology and Pathology, by Charles F. Carter, M. D., and Alice L. Smith, M. D., ($5.50. 5th Edition. *C. V. Mosby Company, St. Louis 3, Mo.)*, is written to bring the subject up to date for the student nurse.

The Doctor Looks at Life, by Peter Joseph Steincrohn, M. D., ($3.50. *Greystone Press, New York 13, N. Y.)*. In a warm, humanly fashion, the author of **How to Stop Killing Yourself** and several other works designed to give courage to the handicapped, sets forth his rules for living a happy life.

An Atlas of Surgical Exposures of The Extremities, by Sam W. Banks, M. D., and Harold Laufman, M. D., 552 illustrations on 179 plates, ($15.00. *W. B. Saunders Co., Philadelphia, Pa.)*, fills a long-felt need for detailed pictorial presentation of surgical exposures—often the most important step in the operation.

Clinical Diagnosis by Laboratory Methods, by James Campbell Todd, M. D., Arthur Hawley Sanford, M. D., and Benjamin B. Wells, M. D., ($8.50, 12th Edition. *W. B. Saunders Co., Philadelphia 5, Penna.)*, brings up to date this classic in clinical pathology.

J. Meller's Ophthalmic Surgery, Revised and enlarged by Professor Dr. J. Bock, Translated and edited by Ray K. Daily, M. D., and Louis Daily, Jr., M. D., ($12.00. Sixth Edition. *The Blakiston Company, Inc., New York 22, N. Y.)*, is a modern revision of a well-known handbook of surgical operations on the eyeball and its appendages.

Physiology of Exercise, by Laurence E. Morehouse, Ph. D., and Augustus T. Miller, Jr., Ph. D., M. D., ($4.75. 2nd Edition. *The C. V. Mosby Co., St. Louis 3, Mo.)*, important because of its up-to-date treatment of fatigue, fitness, and training. Of real value in work as well as in sports.

Brain Mechanisms in Coronary Disease, Causation, Treatment and Prevention, by N. E. Ischlondsky, M. D., (25/- net. *Henry Kimpton, 25 Bloomsbury Way, London, W. C. 1, England)*. The author's previous monograph (1930) on Neuropsychic Activity and Brain Cortex laid the foundation for true psychosomatic medicine. That text was based upon his researches into the conditioned reflex. Now with the concepts and research methods thus developed, Dr. Ischlondsky approaches the problem of coronary disease. Here is a physiologic interpretation of what we physicians vaguely refer to as stress and strain, "hustle and bustle" of the "high pressure" of modern living.

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JONATHAN FORMAN, M. D., *Editor*

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Sensible Approach to Childbirth

LEON HIRSH, M. D.

BECAUSE of widespread interest in the subject, it is not uncommon to hear questions pertaining to the actual conduct of the natural childbirth. One is often asked, "What do you give the patient?", or "Are drugs used?", "Is the patient satisfied during labor?", "How is the labor managed?", and "If drugs are used, is it natural childbirth?"

First, it must be emphatically emphasized that the patient is adequately trained during the pre-natal period and is aware in advance of what is to happen and so is capable of cooperation. It is this teamwork between patient and doctor with knowledge and understanding in which each has confidence in the other, that makes the natural delivery a satisfaction to all concerned, and with the elimination of unnecessary hazards.

CONDUCT OF CHILDBIRTH

Herewith is a portrayal in sequence of the actual conduct of childbirth, sensibly approached, as carried out in a large private general hospital:

When the patient first arrives at the hospital and the patient's condition permits, she is immediately taken to the registration desk and registered in, placed in a wheelchair, and taken to a labor room. Here she is assigned to her bed, her civilian clothing changed to hospital gown, and she is prepared for examination. Next, she is examined by the labor-room personnel and her doctor, and her stage in labor determined and recorded, including the location of the fetal heart tones. An enema is given. None of this is new or startling, or bewildering to anyone including the patient, for she has been advised and expects each step in order.

Then, a little seminar is held between the patient and her doctor. The principles of natural childbirth are quickly reviewed, what her stage in labor is at this time, what is going on, and what is to be expected. Women are usually sent to the hospital as soon as active labor is diagnosed. We prefer to send them in a bit early to insure the hospital personnel adequate time to prepare the patient, and likewise permit the patient to get adjusted and acquainted with personnel.

After she is prepared and initially examined, the patient is permitted to leave her bed and join her husband. At times they just talk; sometimes they play trivial games. During the early stages, relaxation and proper breathing are stressed.

At about the stage of complete dilatation, or earlier in a slow case, or when the woman begins to complain of backache, (patients have been taught to watch for this point), they are usually re-examined, and again told of the position, what progress has been made, and what they are doing relative to labor. If this backache is uncomfortable, and the mother feels that she needs a little assistance, massage or an ice pack applied to the sacral and lower lumbar area, usually suffices.

Sometimes at an earlier stage, the women will complain of the bearing-down sensation, or are a bit fearful in spite of their training, and re-

Submitted March 6, 1953.

The Author

● Dr. Hirsh, Cincinnati, a life member of the American Committee on Maternal Welfare, is on the staff of Good Samaritan Hospital and St. Mary's Hospital.

quest medication. In this event 50 to 100 mgm. meperidine® is used, and may be repeated if necessary, but usually one dose suffices.

If a posterior position is encountered, the woman is advised to be prepared for a long second stage, and to concentrate on her relaxation and breathing, and to conserve her strength.

Advising the mother of the findings at each examination, such as a nickel's worth of dilatation, a quarter's worth, a silver dollar's worth, etc., is always reassuring. These bits of information, coupled with other reassurance, has found a place in the armamentarium and is helpful. If the bearing-down sensations in labor become troublesome, or for that matter, even if the backache at the stage of complete dilatation is annoying, use of trilene® administered with the Duke mask, may be all that is required. All women are trained and instructed in the use of this equipment during the pre-natal period.

PROPER BREATHING

At the stage of complete dilatation, multipara are placed on the table; primipara when the head reaches the perineum. Throughout the first stage, relaxation and abdominal breathing is stressed. During the second stage, costal-sternal breathing and a helpful position where needed are brought to the fore. During the third stage, abdominal breathing is again used, and sometimes is used at the end of the second stage to bring the head over the perineum. It is at this point of bringing the head over the perineum that the short, quick types of abdominal breathing with its accompanying hyper-ventilation is of value.

RELAXATION STRESSED

Throughout all of this progress in labor, the mother is constantly being advised of her advancement, and encouraged in a sympathetic understanding manner. An endeavor is made to avoid hurry and excitement. Relaxation is stressed. The patient is reminded of postural positions that are helpful.

As soon as the mother is placed on the table, she is evaluated as to how well she has labored and whether she needs assistance; and she is asked if she desires assistance. When the mother desires it or if it is felt that it is going to be desirable, pudendal block is used. If on the other hand, the mother is doing nicely without it, and she does not request it, it is not used. The patient is catheterized.

Where episiotomy becomes necessary, it has been found that it often can be adequately done after the pressure of the head numbs the perineum. Especially is this true in slower cases. If the obstetrician is fast enough, this numbness is adequate for the repair. Procaine solution for infiltration is always available, but spinal anesthesia is never used!

When the head is crowning, the mother's head and shoulders are supported on a pillow, and she is told that her baby is about to be born, and now is the time for her to see the presentation. When the infant is completely born, it is placed on her abdomen and she is permitted to hold it, her hands still being under the sterile sheets and drapes.

If the mother desires to be anesthetized for the actual delivery of the head over the perineum, as sometimes happens, a bit of nitrous oxide and oxygen is the most that is required. Usually, however, trilene® suffices for the entire procedure. Women are satisfied with it. For the most part, women prefer the thrill of seeing their baby brought into the world.

Delivery of the placenta is not hurried, but the episiotomy, where done, is repaired as quickly as possible.

The placenta is permitted to deliver in its own free natural manner. After delivering the placenta, the mother is rested a bit and may even be given a cup of tea and some crackers if she desires (and hospital personnel are not too busy). She is then placed on the cart with her baby and delivered to the presence of her husband. The baby is then taken to the nursery and the mother to her room where she remains in the company of her husband. Modified rooming-in is available for private room patients.

In a sensible approach to childbirth, it is the pre-natal training and preparation, together with the management of the labor, that take on a new and great significance! The actual delivery is in no way mysterious, but is highly gratifying to all concerned.

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Low-Temperature Treatment of Pork

Following a brief historical review of the subject, the more recent studies on the effects of rapid freezing temperatures on trichinae are discussed. Data thus far are limited. These data indicate, however, that pork may be rendered safe against trichinosis by (1) rapidly lowering its temperature to —35°C., (2) by an initial rapid lowering of its temperature to —18°C., with subsequent storage for 3 days at the same temperature. Thus, a very short time, a few hours only, would be required to render pork safe against trichinosis by a rapid freezing method, instead of up to 20 days prescribed under present Federal regulations.

The question is considered of the practicability and the desirability of adopting a quick-freezing method to render all pork, intended for interstate shipment and for local sale within a city, free from infective trichinae.—Donald L. Augustine, Ph. D., professor of Tropical Public Health, Harvard University, Boston, Mass.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

Gamma Globulin in the Prophylaxis of Poliomyelitis
A Critical Analysis of Available Data

ALBERT B. SABIN, M. D.

THIS paper presents an analysis of the available experimental and epidemiologic data on the use of human gamma globulin in the prophylaxis of poliomyelitis, and offers some general principles to guide the practitioner in the application of current knowledge.

Gamma globulin, prepared from large lots of adult human serum, contains antibody against all the three known types of poliomyelitis virus. The unconcentrated serum of a convalescent from the clinically recognized disease has antibody in comparable amount against the infecting type, but may or may not have antibody against the other two. The concentration of antibody in the serum of adults without a history of clinically recognized poliomyelitis varies over a wide range from zero to the level found in the serum of convalescents. Accordingly, one may expect that different lots of gamma globulin may also vary considerably, depending on the size of the pool from which it is prepared and the efficiency of the technical procedures used. Actually there is as yet little or no information on the variability in the amount of the three types of poliomyelitis antibodies in different lots of commercially prepared gamma globulin as measured by an acceptable method of assay.

Prior to the field tests on human beings, experimental work on animals had demonstrated that only very large amounts of antibody, amounts too large for practical use in human beings, given **before** infection were capable of preventing paralytic poliomyelitis. When enough antibody was given before inoculation of the virus it was possible to prevent the disease even when the virus was injected directly in the brain. The issue, therefore, was not whether large amounts of antibody could prevent poliomyelitis, but whether amounts small enough to be practical would have a prophylactic effect on the naturally acquired infection.

HUMAN FIELD TESTS

The field tests on human beings were undertaken before any information was available as to the amount of gamma globulin of known potency that had to be injected per pound body weight to obtain a barely detectable level in the serum at the time of inoculation. It is noteworthy that such information still is not available for the antibody against Type 1 poliomyelitis virus, that is, against the immunologic type responsible for almost all large epidemics. The argument was that it was doubtful whether the precise natural conditions of infection could be imitated in animals, and since the answer would ultimately have to be obtained in human field tests there was no point in waiting for orientation from experimental studies on monkeys.

From The Children's Hospital Research Foundation, University of Cincinnati College of Medicine. Aided by a grant from The National Foundation for Infantile Paralysis.

Read before Section on Pediatrics at the Annual Meeting of the Ohio State Medical Association, Cincinnati, April 22, 1953.

The Author

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ARBITRARY DOSAGE CHOSEN FOR PRACTICALITY

An arbitrary dose of 0.14 cubic centimeters of gamma globulin per pound body weight was selected, because it was considered practical and not because there was any evidence that this dose would transmit enough antibody to remain detectable for any known period of time in human beings. Subsequent tests on children and adults by Rhodes and his associates in Toronto,[1] using a preparation of gamma globulin of very high potency against Type 2 (Lansing) poliomyelitis virus in a dosage of 0.12 to 0.42 cc. per pound body weight revealed either no demonstrable antibody or nothing very significant within four days after injection.

Subsequent to the beginning of the field tests, Bodian[2] reported an experiment on a small number of monkeys which suggested that small doses of antibody, just enough to be detected in the serum immediately before administration of the virus, may protect against paralysis produced by feeding Type 1 poliomyelitis virus. However, the precise concentration of antibody against the virus used in the experiment was not known, and the experiment has not been repeated on larger numbers of monkeys to see if the results are reproducible. The point here is that there is no great backlog of experimental data to help us interpret the results obtained in the field. These results must be judged on their own merits.

MANAGEMENT OF TESTS

The field trials were planned with great care by Dr. Hammon and his associates, and a tremen-

dous amount of work had gone into their performance and the collection and analysis of the data. The field tests included a control group of children who received gelatin instead of gamma globulin, and the physicians who diagnosed subsequent illness among the inoculated children did not know which injection they had received. This was an important and necessary precaution, and it was hoped that the injection of gelatin would not increase the incidence of paralysis in a manner comparable to that observed in certain epidemics following inoculations against pertussis and diphtheria. The field tests lacked another important control group such as might have been obtained by giving a placebo by mouth.

The possibility that gelatin may have increased the incidence of the disease in the control group will have to be considered, however, particularly since Bodian[3] has recently obtained suggestive evidence in monkeys that gelatin may act in such a manner.

CONCLUSIONS REPORTED

On the basis of the combined results of the three field tests, Hammon and his associates[4] reached the following conclusions regarding the effectiveness of gamma globulin in the dosage used:

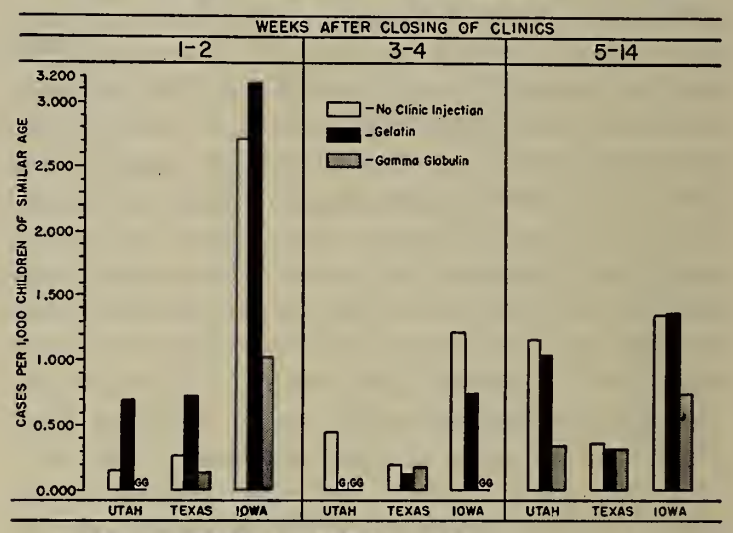
1. The disease was not prevented in those who received gamma globulin one week before the onset of first symptoms, but it may have been made milder.
2. Between two and five weeks after injection there was a marked preponderance of cases among those receiving gelatin as compared to those inoculated with gamma globulin, suggesting that this dose of antibody administered either before infection or very early in the incubation period could prevent paralysis.
3. After the fifth week there was no longer any significant difference in the incidence of the disease among those inoculated with gelatin or gamma globulin, suggesting that the dose of antibody was so small that its effect could not last more than about a month.

STATISTICAL RESULTS

Among the approximately 55,000 children who received either gamma globulin or gelatin in the three field tests there occurred, according to Hammon's final figures, 104 cases of clinically diagnosed poliomyelitis.[5] Although these are all called paralytic, the criteria were such that almost no nonparalytic cases were diagnosed in either gelatin or the gamma globulin groups, and it is possible that by the more usual criteria not more than 60 of these cases would have been diagnosed as paralytic. Certainly when one removes all mild grades of weakness from analysis, there are so few patients left in the group which developed the disease within seven days after the inoculations, that the conclusion that gamma globulin can modify the severity of poliomyelitis of the central nervous system which it cannot prevent seems entirely unwarranted. How a dose of antibody which cannot prevent invasion of the nervous system by the virus can, nevertheless, then modify its effects within the nervous system is beyond comprehension on the basis of all previous observations in experimental animals and human beings.

The final results in all three field tests indicated that 31 clinically diagnosed cases of poliomyelitis, regardless of severity, occurred among those inoculated with gamma globulin and 73

INCIDENCE OF POLIOMYELITIS IN THREE STUDY AREAS



Prepared from data collected by Dr. Hammon and his associates.

CHART I

The detailed data from which this chart was constructed can be seen in Table 7 of the paper by Hammon and associates[5] (J. A. M. A., April 11, 1953, page 1281).

among those inoculated with gelatin. This would be a significant result in favor of gamma globulin if one could be certain that it was not in part due to an artificial increase in the number of cases among those receiving gelatin, and that it was repeatable with different lots of gamma globulin in different epidemics.

ARTIFICAL INCREASE DUE TO GELATIN?

In response to this criticism in private discussions, Hammon and his associates collected information on the incidence of poliomyelitis reported among the children of similar age who received no inoculations in the clinics in the three areas where the field trials were conducted.[5] Hammon has stated that he regarded those figures as unreliable, because there was a tendency, particularly in Texas, not to report all cases of poliomyelitis. If this were indeed true to a significant extent, one would expect a higher incidence of the disease in the gelatin group during the entire period after the closing of the clinics. However, an examination of Hammon's data, presented graphically in chart 1, reveals such a preponderance only during the first two weeks after the closing of the clinics, while in the subsequent weeks the incidence in the un-

inoculated children is either higher than that in the gelatin group or similar to it. This is especially significant when one recalls that the provoking effect of inoculations would be expected to occur during the first two weeks after closing of the clinics.

This analysis does not include the cases which occurred while the clinics were in operation, which was 11 days in Texas and six days in Iowa. It might also be suggested that the two-week period also corresponds to the incubation period of the disease and that the crowding of the children in the clinics, rather than the injection of gelatin, may have been responsible for the consistently higher incidence in the gelatin group than among those who did not attend the clinic. This seems unlikely, however, in view of the abundant observations that a more intimate type of association than mere crowding is required for the transmission of poliomyelitis virus.

What happens when one disregards the gelatin group altogether and compares the incidence of the disease in the uninoculated children with that in the gamma globulin group? It seems best to consider the three field tests separately to obtain some idea of reproducibility of the results. The test in Utah may best be disregarded because the number of cases was too small for consideration, as is evident from the fact that in the third and fourth weeks after closure of the clinics there were no cases in either the gelatin or the gamma globulin groups. The results in Texas are not very impressive, and beginning with the third week after the closure of the clinics, the incidence was the same in all groups—uninoculated, gamma globulin, and gelatin.

The results in Iowa, however, stand out as unique and strikingly in favor of gamma globulin not only during the first two weeks, but also during the entire 14 weeks after the closing of the clinics. Now why this difference between Texas and Iowa? For one thing, we are dealing with small numbers of cases despite the fact that the population groups are in the thousands. The result obtained in Iowa, although statistically significant, may or may not be repeatable. Another thing to be considered is that we are dealing here with a very small dose of gamma globulin which, depending on the actual concentration of antibody in the different lots, may be either on the borderline of effectiveness or totally ineffective. A number of different lots of gamma globulin were used in the field tests, and the ones used in Iowa may have been more potent than those used in Texas.

These lots of gamma globulin were not assayed before use, and even now it is not known what their potency is against the various types of poliomyelitis virus. Furthermore, our biological tests for the assay of poliomyelitis antibody are so crude that the Biologics Control Division of the U. S. Public Health Service has had to adopt the decision that commercially produced gamma globulin which has 2½ times less antibody than the standard would be passed for distribution. And yet, because the dose is so close to the borderline, gamma globulin which has 2½ times less antibody may be worthless in the recommended dosage. Still another thing that needs to be considered is that the viruses which were active in Texas and Iowa may have been different in ways we still do not understand.

URGENT NEED FOR FURTHER STUDIES

It seems to me that the conservative conclusion to be drawn from these field trials should have been that further studies on the use of gamma globulin are indicated and that we need much more information before we can be certain (a) whether or not it will be regularly effective in the small doses that can be used practically, and (b) if it is regularly effective, how best to use a material that is of necessity in limited supply.

The conclusion that the value of gamma globulin in the prophylaxis of poliomyelitis had been proved beyond doubt, has practically halted further urgently needed experimental studies in animals, has made further controlled field studies in this country most difficult, if not, for the present at least, impossible, and has led to the expenditure of millions of dollars by the Red Cross and National Foundation for Infantile Paralysis for the production and purchase of large amounts of gamma globulin, which the public health authorities and physicians of the country are not yet ready to use in an intelligent manner.

ALLOCATION OF SUPPLIES

It is expected that approximately 7 to 8 million cubic centimeters of gamma globulin (or about 1 million average doses) will become available for use against poliomyelitis during the 1953 season. The office of defense mobilization has been charged with the allocation of the available supplies, and with the advice of a special committee of the National Research Council will distribute it free of charge to the various states. The state health departments will in turn distribute it to local communities where it will become available to private physicians.

When it comes to distributing gamma globulin from the national pool, it apparently becomes difficult to be guided by science alone. The people from all the states gave their blood, and so it is considered just that they should receive their share of gamma globulin, whether or not they will have an epidemic of poliomyelitis.

It has been suggested that certain household associates and other intimate contacts of a clinically diagnosed case of poliomyelitis receive gamma globulin. This will probably be recommended as a way out by many state health commissioners but it should be remembered that there

is no scientific evidence that gamma globulin in the dose used will have any effect on the incidence of the disease among those who have already been exposed.

Available evidence indicates that 80 per cent of secondary cases in a household occur within seven days after the first clinically diagnosed case, and that is the period during which gamma globulin had no effect on the incidence of the disease in the field trials. It is quite possible that the remaining 20 per cent who develop the disease after the first seven days were also infected prior to recognition of the first case, and there is no evidence that the small dose of gamma globulin would have any effect on these. Besides, in approximately 95 per cent or more of households there are no secondary cases of clinically recognized poliomyelitis. Even if the small doses of gamma globulin were effective in household contacts, this procedure of administering it would miss more than 90 per cent of the people who develop poliomyelitis.

RATIONAL BASIS FOR ADMINISTRATION

It is clear that if one accepts the suggestive evidence of the field trials, there is only one rational basis for using gamma globulin and that is to administer it to those at greatest risk in areas with a very high incidence of the paralytic disease. I stress here the paralytic disease because we neither need nor want protection against the mild nonparalytic forms of the infection. Furthermore, we should remember that indiscriminate widespread use of gamma globulin, particularly in effective dosage, may interfere with the acquisition of those mild or inapparent infections which give us lifelong immunity.

It is, in my opinion, illogical to point to certain animal experiments in which the injection or ingestion of large doses of virus can produce active immunity despite the presence of a certain amount of antibody in the blood. The fact of the matter is, we don't know what small doses of virus would do under similar circumstances in animals, and we as yet have no information whatever as to what may happen in large segments of the population under natural conditions. It should be pointed out, however, that if gamma globulin could be given in a dosage that was regularly effective in the prevention of both paralysis and infection, I would still regard its use as desirable during severe epidemics, because it is better to acquire one's immunity during interepidemic periods when the risk of paralysis is low than during periods when the risk is very much higher.

The special committee of the National Research Council in considering the question of using the available gamma globulin in 1953 on a national basis in areas of greatest epidemic incidence found itself unprepared for the administrative work that would be required. It would have meant that some supreme court would have had to be in session all summer to decide which areas should get it and which should not, and how much. It would require a staff of epidemiologists to make prompt investigations all over the country, and to set up criteria as to what constitutes an epidemic.

There is no difficulty in recognizing the very severe ones, but not all epidemics fall into the clear-cut categories. The decisions will, therefore, have to be made by each state on how best to use the allotment which they will receive. I would therefore like to make a plea that most of the available gamma globulin be used only in epidemic areas and that the limited amount be assigned to the age groups at greatest risk of acquiring paralysis as well as to pregnant women.

Since there will not be enough gamma globulin for everybody, particularly in epidemics in large metropolitan areas, there should be an opportunity to make further epidemiologic studies on the effectiveness of the selected dose of gamma globulin as a prophylactic agent in poliomyelitis. This would require a good deal of cooperation and concentrated work for a limited period of time on the part of the practicing physicians and health departments in an epidemic area, but it would mean that gamma globulin would be used in the only way for which there is now suggestive evidence that it might have some effectiveness.

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Adams-Stokes Syndrome

The symptom complex which now bears their names was first described by Adams in 1827 and by Stokes in 1846. In the past the basic cardiac mechanism responsible for the symptoms has been considered to be ventricular standstill. More recent investigation, especially during the past 10 years, has shown that Adams-Stokes syndrome may be caused not only by ventricular asystole, but also by ventricular tachycardia or transient ventricular fibrillation. Electrocardiograms taken during a syncopal attack have been published verifying this contention. . . .

Because of the various possibilities that might exist contributing to an Adams-Stokes syndrome, every attempt should be made to ascertain the underlying cardiac mechanism before therapy is instituted.—Sidney Grau, M. D., St. Petersburg; *J. Florida M. A.*, 39:811, May, 1953.

Polio Vaccination?

SAMUEL SASLAW, M. D., Ph. D.

IT is a commonly shared, uncomfortable experience for the practicing physician when he is periodically interrogated by patients or their families about a new miracle drug or treatment recently described in the lay press. These announcements frequently follow or even precede the publication of a preliminary report in a purely scientific or specialized journal which is not read customarily by the majority of practicing physicians. Thus, when a rapid-fire series of "announcements" about polio appeared, as they did in the past year, the flood-gates were broken open by the surge of a polio-conscious, polio-indoctrinated public.

What can we, as physicians, do to substitute for this anxiety state an optimistic but restrained waiting period for the possible development of a proved effective prophylactic agent? The use of gamma globulin is merely a temporary uneconomic and grossly inadequate tool for any large scale passive protection program. Since this subject is discussed by Dr. Albert B. Sabin in an accompanying article, it is the purpose of this communication to consider the potentialities of active immunization.

The Author

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PROPHYLAXIS

As with any infectious disease, the ideal condition for prophylaxis would be the general availability of a safe and effective immunizing agent. Although the virus of poliomyelitis was first isolated in 1908, no proved effective vaccine is generally available at this time. One of the greatest obstacles towards progress was the lack, until very recently, of an adequate practical means of propagation or culture of the virus agent. Numerous investigators sought animals and materials more convenient than the monkey for a virus culture medium.

Except for the monkey, until 1949 the virus had been grown successfully only in tissue cultures containing human embryonic nervous tissue. However, in 1949 one type strain (Lansing) was found capable of multiplying in cultures containing human embryonic skin, muscle and intestinal tissue. Subsequently in 1950, a second type strain (Brunhilde) was likewise propagated in human embryonic skin and muscle. Since that time numerous tissue culture techniques have been attempted and to date all three strains of polio virus have been cultivated in human embryonic tissues and in addition in mature human kidney and uterus. One strain (Lansing) has also been cultivated in mature human thyroid, foreskin and testicular tissue cultures. Thus, a variety of certain human embryonic and mature tissues, as well as monkey kidney and testicular materials have been shown to be suitable for tissue culture.

Previous attempts at active immunization of humans were first described in the early 1930's but were unsatisfactory because of the use of monkey central nervous system tissue containing only a single strain of polio virus in which vaccine purification and inactivation were not adequate. At present three main types of polio virus (Brunhilde, Lansing and Leon) have been identified. More types, or variants may occur in the future.

Other studies in man by Koprowski recently demonstrated antibody formation in 20 volunteers who were fed an attenuated strain (Lansing) of polio virus which had been propagated in rodent nervous tissue. However, this virus was still capable of causing paralysis in monkeys when inoculated intracerebrally. Thus, studies of this nature, as well as many animal immunization procedures preceded the report by Salk published recently in *The Journal of the American Medical Association.*

WARNING

Although the author was extremely conservative in his paper, premature expectations by the lay public have arisen. Briefly, Salk's studies described the development of antibodies in humans following immunization with all three types of inactivated polio virus cultures emulsified in mineral oil. It must be remembered that he employed monkey kidney or monkey testicular tissue. Only 161 patients were immunized and 79 already had had paralytic polio and many had antibodies against one or more of the three types of polio virus. Also, 63 other patients had a high incidence of polio antibodies before immunization. Although antibodies induced by immunization were still present 4½ months later, one doesn't know yet how much longer they persist and how much protection is afforded.

All of the foregoing discussion is not meant to disparage but rather to serve as a reminder

Submitted May 20, 1953.

of part of the many facets that are involved in the search for a polio vaccine. Certainly we must realize that there are still many unknowns and problems to be completed. If, and when any of the experimental vaccines should prove themselves to be effective in field studies, many probblems will still remain to be answered.

Thus far the type of tissue required for the culture of polio virus would pose a problem from a mass-production standpoint. Certainly mass collection and utilization of human embryonic tissue would meet with difficulties. Even with the numerous hysterectomies occurring in the United States, the supply of uteri would be infinitely small. Human mature kidneys and foreskin would also create a problem in collection. The monkey traffic into the United States would have to be tremendous if a generalized program were instituted employing monkey kidney or testicular material.

However, one should not construe the previous remarks as being facetious. American productivity and ingenuity have succeeded in the past in overcoming technical obstacles.

SUMMARY

In summary, one must take a polio inventory periodically and arrive at a reasonable explanation to satisfy the questions of our patient groups. Clarification of the technical and biologic problems involved, as heretofore outlined, may help towards a better appreciation of the long term nature of the situation. Then, perhaps, the medical profession will not be accused of "withholding" valuable therapeutic agents from an anxious public.

Circumcision

Circumcision is perhaps the oldest and certainly the most frequently performed of all the surgical procedures. The benefits of the operation have become manifest and its present wide application is well deserved. With the passage of time, the complex rituals associated with its origin in antiquity have fortunately become simplified or have been discarded entirely.

It is said that the first records indicate that some type of circumcision was performed by the Egyptians prior to 2400 B. C. However, such operations in no way resembled our present-day thoughts on circumcision. They apparently consisted of mutilation of the phallus in the performance of local ritual.

According to the Old Testament, circumcision was practiced by Abraham about 1850 B. C. The operation was ordained to remind the Jews of their fidelity to God. Although its exact origin is not clear, it is generally agreed that this was the first circumcision to resemble the operation which is performed today.—Herman I. Kantor, M. D., Dallas; *Texas State J. M.*, 49:75, February, 1953.

KEEPING UP WITH MEDICINE

• OF THE OVER 800 chemicals that have been suggested for use in processing our foodstuffs, it is estimated that at the present time 704 are in use. Of these 704, only 428 are known to be reasonably safe for human consumption.

* * *

• CHEWING paint off cribs, toys, furniture, and window sills gives lead poisoning a high place among the common causes of death from poisonings in the early years of life.

* * *

• REEDUCATION based upon relaxation can relieve excessive fatigue in relatively stabile individuals.

* * *

• THE FACT that the diabetic patient can now under certain conditions get life insurance is a fine commentary on the advances made in the management of this disease.

* * *

• ALL OF THE chemical reactions within the cell are made possible by the action of enzymes. For each specific reaction, there is a specific enzyme which initiates and accelerates the reaction. This can only mean that there are thousands of enzymes in every cell.

* * *

• SOME ENZYMES contain atoms of heavy metals such as iron and copper and when these elements are present in insufficient amounts in the animal organism the respective enzymes are inactive and eventually are destroyed.

* * *

• IN ANY ATTEMPT to understand disease the fundamental question involves the reaction of the individual cells to their environment. DISease is always an adaptation failure.

* * *

• ACCORDING TO the newer concepts of intermediary metabolism, the dynamic biochemical equilibria of the body cells and their internal environment (blood and tissue fluids) are interdependent. Therefore the blood may be used for an investigation of the metabolic status of the cells.

* * *

• THE DEPOSITION and release of lipids from the fat cells is under the influence of the autonomic nervous and the endocrine systems. When hypercholestremia persists it produces an atherosclerosis of the larger arteries.

* * *

• THE TREATMENT of nephrosis should be directed towards the elimination of the factor causing the hypercholestremia.

* * *

• BIOCHEMICAL STUDIES of the heart in congestive failure have revealed marked changes similar to those found in the thyrotoxic heart.—J. F.

A Formula for Child Safety*

GEORGE M. WHEATLEY, M.D., M.P.H.

ONE of the most significant developments in American medicine in the past several years has been the growing interest of the medical profession in child safety. More and more physicians, aware of the great toll of death and disability from this cause, are giving attention to ways and means of accident prevention.

It is not accidental that the leadership of this movement is found among physicians who are concerned with the care of children. This segment of the medical profession has already successfully applied preventive medicine to private practice. They have taught parents the value of immunization, of applying the science of nutrition and of child development. More and more parents, as a result of this application of preventive medicine, and the confidence it engenders, look to their physician for guidance in all matters pertaining to the health at least of their children. Evidence of this was obtained in the American Academy of Pediatrics' Child Health Study.

Today, the major part of pediatric practice is concerned with health supervision of the apparently well child. Perhaps the significance of this new movement is best expressed in the words of one pediatrician who wrote: "With a third of all children who die, dying of accidents, I have come to the conclusion that as long as I work only on the prevention of disease, I am only partly serving my patient's interest."

Today I wish to describe briefly the program of the Committee on Accident Prevention of the American Academy of Pediatrics, the progress we are making in studying several types of accidents, and some of the educational aspects of accident prevention in pediatric practice.

THREE OBJECTIVES

The Committee on Accident Prevention of the American Academy of Pediatrics was organized in October 1950. It has three broad objectives in attacking the child accident problem: (1) education, (2) engineering, and (3) enforcement. These are the three traditional objectives of accident prevention. Our Committee interprets these three E's as follows:

Education: Informing all physicians who supervise children in the child accident problem. Encouraging physicians to educate parents in child accident prevention through the physician-parent relationship and through community education in cooperation with health agencies, nursing groups, parent-teacher associations, schools, safety clubs, etc.

*Presented before the Section on Pediatrics at the Annual Meeting of the Ohio State Medical Association, Cincinnati, Ohio, April 22, 1953.

The Author

● Dr. Wheatley, New York City, Third Vice-President of The Metropolitan Life Insurance Company, is chairman, Accident Prevention Committee, American Academy of Pediatrics.

Engineering: Working with allied professional groups such as American Standards Association and its affiliated organizations to develop manufacturing standards which would minimize childhood accidents.

Enforcement: Studying legislation designed to prevent child accidents, for example, suggesting improvements in Caustic Poisons Act and giving support to well-conceived legislation directed at child accident prevention, e. g. Canfield Johnson bill.

ACTIVITIES OF THE COMMITTEE

We have communicated directly with all members of the Academy (3,000), through a series of brief letters. As a result of the first communication we found that most Academy members give advice on accident prevention as a part of the systematic health supervision of the infant and child.

Our second communication contained a questionnaire to secure information on hazards which would be appropriate to bring to the attention of the American Standards Association, such as flammable clothing, poorly constructed children's furniture, and toxic paint. An important by-product of this inquiry is the discovery that poisoning is a major problem to the practicing pediatrician. Tabulated data from the questonnaires follow:

TOTAL CASES	2,781	8.4% fatal
Poisonings	1,370	50% of all cases
Burns	793	30% of all cases
Flammable cloth	40 fatal 443 non-fatal	3% of all cases
Strangulation or suffocation	136	but 1/5 of deaths
Between bars of playpen	6 fatal 32 non-fatal	
Harness or straps	18 fatal 34 non-fatal	

Poisonings	Fatal	Non-Fatal
Toxic substances in paint	23	255
Ingestion of medicines	20	357
Ingestion of disinfectants	19	696

POISONING AGENTS

It is apparent that misuses of household agents are important causes of poisoning in children.

In this partial survey, among the medicines, aspirin and barbiturates appear to be the most common causes of poisoning; among household agents, pesticides and petroleum products such as kerosene are frequent causes. A number of cases of childhood lead poisoning have been reported in Baltimore, Cincinnati, and St. Louis. Lye poisoning is more common in the southeastern sections of the country.

The frequency of poisoning with a wide variety of new agents has led us to the conclusion that toxicological laboratory facilities should be available in strategic parts of the country. We have explored this in New York City where no facilities now exist except in the office of the Chief Medical Examiner for the City of New York. The New York Academy of Medicine has a special committee studying the ways and means of developing such toxicological service for New York City physicians. Dr. Edward Press of Chicago has initiated a committee there of the heads of pediatric services and toxicologists to plan a center for this community.

SAFETY EDUCATION PROGRAM

The Committee has had the assistance of the Metropolitan Life Insurance Company in developing its program. Materials that have been worked up include:

(1) *Accidents: Childhood's Greatest Health Hazard,* a reprint of the proceedings of the first joint meeting between the American Academy of Pediatrics and the National Safety Council, on October 19, 1950.

(2) An exhibit "Help Immunize Me Against Accidents," first shown at the American Medical Association meeting in Atlantic City in June, 1951, and the American Academy of Pediatrics meeting in Toronto in 1951. Since then, the exhibit has been shown at many local safety meetings throughout the United States.

(3) A brochure, *Are You Using the New Safety Vaccine?,* which has been prepared to inform the medical profession of the child accident problem and to interpret childhood accidents in relation to normal growth and development. Approximately 42,000 copies of this brochure have been distributed in 27 states in cooperation with the state medical societies which paid the postage (in some cases it was paid by the state health departments). The Metropolitan Life Insurance Company paid for the production of the brochure and has developed a small booklet patterned on the brochure entitled *A Formula for Child Safety.* The latter booklet is being distributed to the public through physicians' offices, child health stations, nursery schools, and through other channels of distribution directly into the home. A child safety check list will soon be published by the Metropolitan. It is hoped that it will be an aid to parents in checking conditions and practices which may threaten their children. It grew out of a suggestion by a pediatrician that he would like to have such a publication to give parents.

The Committee has prepared talks and slides to accompany the exhibit for use by pediatricians when called upon to discuss the child accident problem with community groups. In many states, pediatricians are active in this work.

The Committee has sponsored two joint meetings with the National Safety Council—one in October 1950 and one October 20, 1952—held in Chicago between the American Academy of Pediatrics and the National Safety Council. At the latter a report on a study of accident proneness was given by Dr. William Langford, Babies Hospital, New York. A report on a study of mechanical suffocation was given by Dr. Sidney Farber of Boston, and a half-hour radio dramatization entitled "Accidentally Speaking" was given through the facilities of the National Broadcasting Company. This coast to coast broadcast featuring Gene Lockhart was financed by the Health Information Foundation.

SAFETY IMMUNIZATION

The heart of accident prevention is education. We believe the physician as family counselor in child rearing has the opportunity and the responsibility to include accident prevention advice in the health supervision program for the child. We have likened this kind of advice to a new vaccine to be offered. But it is an immunization to be given to the parents rather than the children.

This safety immunization, as we call it, must fit the needs of the individual child and his environment. The needs can be seen most clearly by the physician who understands the home situation and is familiar with the child's growth and development. The vaccine is intended to increase parents' knowledge, understanding, and confidence in child management and care. Its administration should be timed to help parents anticipate risks for which reasonable precautions can be taken at various stages of development.

Accident prevention education handled in this way becomes a natural part of the child-rearing program and is not likely to produce attitudes of anxiety, fear, and over-protection. The "dose" and the "technique" of safety education is a matter of professional judgment. The child's personality, his muscular co-ordination, his physical environment, and the parents' emotional attitude toward the child and the doctor, are factors which determine **what, when,** and **how much** should be given. To supplement this personal guidance is the booklet *A Formula for Child Safety.*

To help the physician in determining the "dose" and the "technique" there are many suggestions by authorities in this field. For example, Press has proposed that physicians give

parents a home safety check list about the time the child is 8 months old. At this age, the accident hazard begins to increase and at this age the baby's disease immunization series begins.

A thorough check list on home and child safety may be obtained from the local health department or safety council and soon from the Metropolitan Life Insurance Company. Such a list, presented to the mother and taken home, filled out carefully and at a subsequent visit discussed with her, will do much to impress the whole family with the importance of the subject. The Children's Hospital of Boston has published a useful booklet on the prevention and first aid handling of pediatric emergencies which every home with children should have. The Cincinnati Children's Hospital also recently published an excellent pamphlet.

ENVIRONMENTAL INSPECTION

When the physician makes a home visit, there is opportunity for education too. Finding and advising corrective measures for such accident breeders as a carelessly placed roller skate, a medicine cabinet easily accessible to little hands or unguarded stair or window may be as significant a contribution to preventive medicine as recommending the removal of a pair of diseased tonsils. Such "environmental inspection" is an effective way to educate. Most people must have their attention directed to hazards before they recognize them.

One of the physician's most valuable allies in such educational efforts in many communities is the public health nurse. She is often able in repeated visits to give parents guidance for which the physician has neither time nor opportunity. In her own care and instruction, when bathing the new baby, demonstrating the preparation of the formula, etc., she can impress upon the family proper techniques which may avoid accidents. She is also in a position to know individual home conditions and to point out constructive action in regard to hazardous situations.

SOME ATTITUDES TO RECOGNIZE

A major factor in developing a protective titre with the new safety vaccine is the attitude of the parents. A multiplicity of accidents in spite of all reasonable care, may lead some parents to take the position that "accidents will happen"; that nothing can be done to prevent them. This attitude of the futility of education and control measures can be reasoned with by pointing out the success in preventing accidents in industry. Occupational accidents were once regarded as part of the inevitable wear and tear of production. When it was demonstrated that this waste of men and materials was controllable by engineering, enforcement and education, industry applied these methods so effectively that today workers are safer on the job than on the highway or in their own homes.

OVERANXIETY

Other parents may be terrified and overwhelmed by thoughts of all kinds of accidents threatening their children. This state of mind robs the parents of the confidence and will necessary to carry out a consistent education program. Such confusion and indecision of parents may only increase the likelihood of accidents by sapping the child's own self-confidence in learning to meet situations of potential danger. The physician can help overcome this overanxiety by explaining that all these dangers do not constantly threaten the child; that there are stages of growth when certain hazards are very real and other ages when these are not important.

By giving parents definite preventive measures which will help safeguard their children at specific ages of development, the physician is substituting a positive attitude and a program for one of confusion and overanxiety. This is good safety education and also good mental hygiene.

OVERPROTECTION

A third attitude which may be encountered is one of overprotection. The lesson of protection of the infant may be so literally applied that as the child reaches the runabout stage, no calculated risks are permitted. The crawling, exploring child is hovered over at every waking moment and perhaps even when asleep. This kind of management may stunt the development of the child's own sense of self-preservation. He tends to learn timidity and parental dependence rather than self-confidence and an increasing measure of independence in dealing with the world about him. Here again, the physician, as family counselor, can help the family develop a constructive approach to child safety.

Children, like everyone else, learn best by doing. Falls are inevitable in learning to walk. Failures associated with bumps and bruises, cuts and burns will occur at other stages of the developmental or learning process. Parents must expect these results of the trial and error method and while staying in the background be alert to prevent a serious situation from developing. They should use minor mishaps causing bruises, cuts and burns to point out in an objective manner the cause and effect relationship of these injuries instead of diverting or diluting the experience for the child, as Dietrich says, "by rewarding tears with kisses and blood with candy."

THE OVERZEALOUS PARENT

At the other extreme is the overzealous parent who is grimly bent on teaching the child to save himself before he is out of the diaper stage. Every misadventure of the child is pounced on and furnishes the text for a safety lecture in words beyond the child's comprehension. Ac-

cident prevention becomes a day-long succession of frustrations accompanied by slaps and yaps. "Get down," "Be careful," "Don't do that!" "You fool." This can result in timidity or rebellion or the protective development of a "deaf ear."

The attitude most likely to succeed in applying the formula for child safety is a common sense blend of the previously described states of mind. Actually this concept of accident prevention means recognizing the common or serious hazards or accidents at certain stages of the child's growth and development, and taking specific action to protect and educate the child consistent with the child's ability to comprehend and his progress in development. It is a plan offered where none existed before to attack a serious child health problem. It appears reasonable because it incorporates the demonstrated principles of child growth and development and the successful techniques of modern education. To be successful, it requires not only an informed physician willing to offer this form of anticipatory guidance but also parents who accept accident prevention as basically a responsibility belonging to them and their child.

This point is worth stressing because it is at the root of future progress in accident prevention. When accidents happen it appears to be human nature to put the responsibility or blame on someone else. As an illustration consider the aftermath of the succession of drownings of young children in water-filled excavations on Long Island.

All of the public's emotional distress over these tragedies appeared to be expressed by indignation against the owners of the property where the children lost their lives. Special legislation and fencing or filling in of these bodies of water has been demanded. Calmer examination of the facts shows that one body of water where three children drowned—one aged 11, the others about six and seven—is already fenced in and has been enjoyed for boating and swimming for many years by a large number of families in the community. The children who drowned gained access to the water by breaking through the fence. The other drownings involved two children both under five who were playing unsupervised near a natural body of water.

The runabout, who lives near water should have an enclosed play space. At three or four, he might begin to have some instruction in swimming. When he's playing in shallow water, he should also be taught the risk of going out too far. Most families with young children who have lived for some time near water understand this.

SUMMARY

Unlike older children, preschool children are not exposed to organized safety education through the schools. They must be reached through the family. The medical profession is the logical authority to give leadership in attacking this problem. It is the doctor who brings the child into the world. It is the doctor who supervises the feeding and health protection of the infant. It is the doctor on whom the family learns to depend for advice in child rearing. It is the doctor who sees the tragic results of accidents. Today with accidents a greater threat to the health of the young child than childhood diseases, parents should expect their physician to add as part of the supervision of the well child which now includes the medical examination, guidance on nutrition, and "shots" against diphtheria, etc., this new immunization—the vaccine of safety education.

WAYS AND MEANS OF ACCIDENT PREVENTION

Such a program of safety education begun in the preschool years by an interested physician and receptive parents, can be the foundation for the development of attitudes and safe practices which should last throughout the child's life. Briefly, and in addition, the following activities are suggested for physicians.

1. Observing, on home calls, hazardous conditions in and around the house and suggesting corrective measures.

2. Giving careful instruction when prescribing medications to reduce the risk of overdosage or careless handling in the home. Elimination of sugar-coated pills which may tempt young palates.

3. Studying the causes of medical emergencies and accidents particularly when the individual appears "accident susceptible," and using this knowledge with the family and with others to help prevent a similar condition in the future.

4. Utilizing accident-case presentations in the hospital or medical society to emphasize ways to prevent accidents as well as to treat them.

5. Helping to develop community educational programs in co-operation with health departments and voluntary agencies and by presenting the facts to the community and local medical society.

APPLYING THE VACCINE OF SAFETY EDUCATION

There are five factors which have to be taken into account in applying the vaccine of safety education in everyday practice:

1. We have to know the common or likely hazards at certain months or years of age. We have some data on this but more needs to be accumulated through research. We must develop effective means of discussing these hazards with parents in a manner which will encourage con-

structive action without creating unnecessary fear or alarm.

2. We must be familiar with the characteristic behavior and drives at certain ages.

3. We must understand the emotional attitude and behavior of the parents toward the child and toward each other. The effect of a disregard of safety practices on the part of the parents should be pointed out. The value of a good example cannot be overestimated.

4. We must know the physical, emotional and intellectual capacities of the individual child.

5. We must know the environment, not only the physical setting, but the emotional climate in which the child is living.

Immunization, dietetics, and antibiotics have greatly enhanced the content of preventive medicine, especially in the health supervision of young children. We propose adding something new—the vaccine of safety education.

AVOID INDUCING FEELINGS OF GUILT

Before closing I must call attention to the importance of preventing or minimizing feelings of guilt in parents over accidents which occur. Every normal parent tries his best to prevent injury to his children. But accidents will happen in spite of all our care. Our ignorance is vast concerning the complex factors which produce an accident. Luck—good or bad—may play an important role in determining whether a mishap ends in stark tragedy or a minor injury. Let us do the best we know how to prevent the original cause of the accident; to learn from our mistakes; and to recognize that children can and do learn from their mistakes—thus reducing the power of Lady Luck.

Let us take comfort, too, in the fact that the accident mortality rate at all ages has been falling consistently for many years. Let us be confident that research and the continuance of our accident prevention efforts will give impetus to this trend. Above all, let us, the physician or the safety expert, in our ignorance of the complex factors involved in an accident, ever remain humble in our relations with parents in the face of the unpredictable. Let parents have faith that the strongest protection is in the loving care they offer their children. The prevention of childhood accidents is today's great challenge to all of us who have responsibility for child rearing.

Cholesterol, the word, means a bile solid alcohol. It acquired its name from the early scientists who first isolated this mono-hydroxy alcohol from human gallstones. It is one of a group of sterols which, when combined with fats, enables them to absorb comparatively large amounts of water. It is one of the constituents of bile which aids in emulsification of fats and by this, aids in their digestion and absorption.—Jos. M. Roberts, M. D., Portland, Ore.; *Northwest Med.*, 52:208, March, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Inject, Injection—However carefully we may inject a medicine into a patient, we are literally throwing the medicine into him. Our words inject and injection are derived from the Latin words "in" or in and "jacere" to throw.

Patella—The knee cap or patella takes its name from its fancied resemblance in shape to a small dish or frying pan. The word "patella" is the Latin diminutive of "patina" a broad shallow dish or pan. Related to this term is the Italian word for a frying pan which is "padella." In 1398 Trevisa wrote "patella is a panne, an open crocke" and in 1693 Blancard described the patella as "a round and broad bone at the joynting of thigh and leg."

Penis—This word was originally a descriptive slang term applied by the ancient Romans to the male genital organ. The Latin word penis literally means a tail and is in turn derived from the Latin "pendere" meaning to hang down. The Romans used a great many terms for the male organ such as clava or club, gladius or sword, ramus or branch and vomer or plough.

Incest—This term which is applied to sexual intercourse between persons of close relationship, literally means unchaste or not pure. It is composed of the Latin prefix "in" or not and the Latin word "castus" meaning pure, chaste or spotless.

Court Plaster—Once upon a time it was the fashion of the Ladies of the Royal Court to cut out little patches which they pasted on their faces or shoulders. These plasters were mostly of decorative designs, but sometimes they showed the family crest or political party. From this practice we obtained by extension our medical term "court plaster." This term while loosely used as synonymous with adhesive plaster really denotes a solution of isinglass spread on silk and allowed to dry and was used to hide small blemishes and to close wounds. The word plaster comes from the Late Latin word "plastrum" which in turn derives from the Greek "plassein" meaning to form or to mold.

Imbecile—This term now designates an intermediate grade of mental deficiency where the mental age is between three and seven years and the I. Q. between 25 and 49. However, the term originally referred to bodily weakness and only later by transference came to be applied to mental weakness. The word is derived from the Latin "im, in" or not, plus the Latin "bacillum" which meant a walking stick. Bacillum in turn being derived from the Latin "baculus" or staff. Hence the term literally referred to a physically weak person, who was unable to walk or support himself without a staff or walking stick.

—Harry Wain, M. D., Mansfield, Ohio.

Medical Culpability and the Abrasive Treatment For Acne Scars

ORD C. BLACKLEDGE, M. D.

A GREAT disservice is often rendered patients by uninformed doctors who, because of lack of knowledge about or experience with a certain medical technique or procedure, arbitrarily condemn it. A glowing example of this warped attitude exists in connection with the new and rather spectacular treatment for acne pits or scars and other such disturbing lesions of the skin. Contact with but one individual whose skin has been damaged by the relatively innocuous condition known as acne vulgaris is all that is necessary to demonstrate how utterly wretched and miserable these unfortunate souls can be.

The more rational and fair-minded physician, who has enough self-confidence and esteem to admit that he is not familiar with the procedure, will not denounce it but will frankly tell the patient that he is unable to express an opinion on it. The patient's hopes for relief from his distressing disturbance are not then completely shattered.

Anyone, especially a physician—a designation which automatically implies above-average education and intelligence—who discourages and berates any form of therapy which has not been proven to be actually injurious and harmful to life and health is actually guilty of more than a disservice to his patients. To put it bluntly, he commits a serious offense which, if considered in the light of ordinary human relationships, could be given redress by recourse to law. If the situation were reversed, it is quite certain that the dissenter's attitude would be somewhat different.

Several articles have been published on the abrasive technique, so little more need be added at this time. As one who participated in its development almost from the beginning, with the opportunity to observe the results obtained as the technique was evolved, the author feels adequately qualified to speak with assurance and conviction on the subject.

PERCENTAGE OF IMPROVEMENT

The improvement in appearance resulting from this treatment may range anywhere from 20 to 70 per cent, depending upon the character of the skin and the nature of the scars. It is not too difficult for those experienced with the procedure to arrive at a fairly close and accurate estimate of the degree of improvement preoperatively and to advise the patient. Seldom is it considered to be worth the effort and inconvenience if the maximum improvement is expected to be less than 50 per cent. Some patients, however, will insist upon treatment no matter what the anticipated degree of improvement, because they are so unhappy about the shadow cast over their lives by their disfigurement.

Submitted January 15, 1953.

The Author

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The lay press was quick to seize upon this new application of an old idea as it was reported in the medical literature and to give it wide and favorable publicity, realizing how important it might be to thousands of unhappy people. The very lives and economic usefulness of these people were being thwarted by their condition, for which so little help had previously been available. Yet recognized and reputable specialists have been known, on numerous occasions, to frown upon and actually condemn the abrasive procedure with absolutely no first-hand experience upon which to base their opposition.

In some instances patients have, in futile desperation, ignored the admonitions of these so-called experts and submitted to the treatment, with astonishing benefit and improvement. One such person readily admitted that her family had spent almost $30,000 vainly seeking relief. The abrasive treatment was the first and only treatment which had effected a noticeable improvement. The gratitude of such individuals is beyond measure, and this alone is almost adequate compensation for the effort which has been expended.

EVALUATION OF PATIENT

As has been clearly stated by others, this is not a procedure to be undertaken lightly by either the patient or the surgeon. Many factors must be carefully considered in the proper evaluation of each case. One who is not interested in taking the time to study the patient psychologically first and then make a reasonable effort to evaluate the lesions and the texture of the patient's skin should not undertake this work. The patient deserves a careful and detailed account of the procedure, the postoperative course, and what may be expected. Finally, he should be

given the privilege of deciding independently and without pressure whether or not he cares to submit to the treatment.

After this has been done, it goes without saying that the person doing the work must possess the necessary knowledge and experience if the job is to be a success, with the maximum benefit derived from one treatment. It is an operative procedure which should be done only in the hospital and under general (endotracheal) anesthesia if any considerable portion of the face and neck is affected. The essentials for a good result are plenty of abrasive material, an abundance of gauze, lots of muscle, good anesthesia, and, last but not least, the knowledge of where to start and when to stop.

REASONS FOR RELUCTANT ACCEPTANCE

The general acceptance of the procedure by the medical profession has been slow for several reasons:

1. A stubborn and unyielding attitude on the part of certain members of the profession and an unwillingness to open their minds and their eyes to a new form of treatment for an old and serious problem for which so little has been available in the way of relief.

2. An unwillingness to believe that anything so simple and mundane as sandpaper could become part of the medical armamentarium.

3. Insufficient knowledge of the structure of the skin and the lesions which are sequelae to such low grade infections of the skin as acne simplex.

4. The lack of a completely satisfactory and standardized technique of photography. Any variation of shade or lighting furnishes the only ammunition needed by the skeptics and cynics, who declare that any noticeable improvement is strictly the result of trick photography. Lighting and composition are so important and still so inconstant by present methods that the pre- and post-operative pictures will often show variations in shade and tone which cannot be interpreted and properly evaluated by the inexperienced eye and lead only to doubt and skepticism on the part of the average observer.

5. The fact that considerable publicity was given to the procedure by the lay press. This is the last and least important reason.

SUMMARY

There has been nothing developed to date in the field of medicine or surgery which closely approximates the beneficial effects of the abrasion treatment for superficial scarring of the skin by such diseases as acne and smallpox. Any blemish or defect which is not a full thickness scar can be improved from the standpoint of appearance by this procedure, thus bringing about great psychological and emotional rehabilitation of the unfortunate victims.

This technique has been carefully and thoroughly worked out and tested to the complete satisfaction of those who are using it, as well as those who have shared its benefits. Its use should be encouraged and more widely endorsed by the medical profession in order to make its help available to more people. In trained hands and in properly selected cases, it can give from 20 to 70 per cent improvement in appearance with a minimum of discomfort and inconvenience.

CONCLUSION

1. Many doctors, through ignorance and/or stubbornness, are discouraging the use of a new and effective method of reducing the disfigurement of acne scarring, commonly known as the abrasive treatment.

2. Individuals with superficial scarring of the skin are frequently handicapped both socially and economically to the point where they become borderline mental cases and are therefore desperately in need of help to restore their self confidence and maximum usefulness to society.

3. The abrasive treatment by the use of coarse sandpaper, as a hospital procedure under general anesthesia, offers the best hope of any technique thus far developed in the treatment of this condition, and its use should be encouraged by the profession rather than discouraged, as has been the case in the past.

Sensitivity to Cosmetics

While one would expect cosmetic sensitivity to be limited to the female, this is not a clinical fact as cutaneous sensitizers are found in shaving cream, hair tonics, aftershaving lotions and perfumed soaps, thereby affecting a large portion of the male population. While the usual cosmetics produce a certain percentage of dermatitis, it is the recent addition of cold waves, hair dyes, lacquers and de-kinkers that are responsible for the increase in cosmetic dermatitis.

A review of a listing of the common cosmetic irritants and allergens shows over 60 chemicals capable of producing disease in man. Of these, the oils found in perfumes are the most common offenders. A perusal of the list shows over 18 such oils incorporated in most of the scented cosmetics available commercially. The following are a few of the oils usually found in the various cosmetics: oil of bergamot, oil of cananga, oil of geraniol, oil of heliotropine, oil of hydroxycitronellal, oil of lavender, oil of lemon, oil of lemongrass, oil of linalool, oil of neroil, oil of orange peel, oil of origanum, oil of orris, oil of ylang-ylang, oil of cassia (clove), oil of peppermint, oil of spearmint, and oil of wintergreen.—Louis E. Garston, M. D., Torrington; *Connecticut State M. J.*, 17:18, January, 1953.

Tension State—A Practical Approach

GREGORY G. FLORIDIS, M. D.

THE literature as well as statistical surveys indicate that the so-called "tension state" is rapidly becoming the most common "disease" the physician encounters in his practice. Many terms have been applied to this condition but not one, as yet, is universally accepted. Psychosomatic disease, anxiety state, neurosis, functional disease, psychoneurosis, are a few of the terms employed. Tension state probably best describes the clinical or presenting symptomatology of the patient. It has now been well established that approximately one-third of all patients seeking medical aid present purely functional symptoms, the second third a mixed group of both functional and organic disorders, while the last third come to the physician because of serious organic disease.

A two-fold practical approach to this problem is presented, consisting of psychotherapy and intravenous therapy with calcium bromido-galactogluconate.*

ETIOLOGY

The ever increasing stresses and tempo of contemporary life produce emotional reactions which may have physiological reflections. This emotional reaction may be pleasant or unpleasant, expressed or hidden. The physiological reverberations of the unpleasant stress in an acute episode consist of some of the following well known defensive responses: outpouring of epinephrine, tachycardia, mobilization of glycogen to glucose, diversion of blood volume from the splanchnic and renal regions to skeletal muscles, etc. Wolff[1] calls them, "protective reaction patterns," and if properly employed they may be of benefit to the individual. This reaction pattern ceases when the "danger" disappears.

However, such patterns may become chronic and, while they may be of lesser intensity, can nevertheless produce a "tension state" that persists as long as the unpleasant stress exists or even longer. Moreover, due to previous sensitizing experiences, there may be no real threatening situations, but associated symbols—conscious or unconscious—that initiate or incite such reactions. Not only disturbance in function occurs, but eventually even anatomic changes may occur, resulting in actual organic disease.

ANATOMIC MECHANISM

Stress acts upon the cortex of the brain and, in turn, impinges up on the hypothalamus. This "master autonomic switchboard"[2] is the center of dynamic integrating functions. It can be influenced by the autonomic nervous system and vice versa. It can be stimulated by hormonal endocrines such as epinephrine and, in turn, react on them.

Submitted March 18, 1953.
*Calcibronat®—Sandoz.

The Author

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DIAGNOSIS

The diagnosis of tension state should be primary and should not be one of exclusion. The conclusion should and often can be reached by the time the history is taken and the physical examination is made. Just because one cannot find any physical abnormalities a diagnosis of functional disease should not be made. In order to be sure of the diagnosis certain criteria should be looked for. Therefore, in taking the history the following pertinent information should be ascertained.

(1) History

(a) *Onset*—Were there some shocking or troublesome situations associated with it?

(b) *Family history*—May reveal institutionalized relatives for mental illnesses. A heavy familial tint of nervous aberrations may decide quickly, psychiatric consultation. Insight into the family life and interrelations may reveal new facets of the patient's personality.

(c) *Past health* often presents neuropathic traits during adolescence or when crises had to be met in life. Relations with siblings, adjustment to school life, work, marriage, and early feeding, bowel and bladder difficulties should be scrutinized.

(d) *System review* may draw attention to emotional instabilities as manifested by fatigue, headaches, nervousness, insomnia, precordial pains, bowel dysfunction, enuresis, and other disorders.

"Good listening to," is all-important as the patient unravels his story with as little direct questioning as possible. When important leads are detected, rephrasing them and injecting them into the conversation may draw important information.

(2) Physical Examination

Patient's reaction to physical examination—sweating, fidgeting, tachycardia, flushing,

hyperpnea, pupillary changes, hyperactive reflexes, hypoactive or absence of reflex, anxiety or depression.

(3) **Conclusions**

Equipped with observations in the history and physical conditions of the patient, the physician is now able to draw certain conclusions:

(a) as to illness—its onset, course, and its manifestations. Organic findings do not explain (or do so in part only) the clinical picture. Diagnosis is facilitated if one looks for an existing conflict that provides the motivation of the symptoms and if the impact of this stress correlates as to time of onset, course, and exacerbations of the illness.

(b) as to patient—pre-psychotic states may be distinguished from functional ones. The patient's personality structure may be evaluated as to ability to adjust itself to the situations, whether there is insight into the problem, if intelligence is lacking for understanding the conflicts involved. Also to be considered are the environmental factors involved and whether or not they are rigid or flexible and warrant manipulation.

TREATMENT

(a) **Psychotherapy**—A practical plan is now outlined for the patient. It has often been said, and rightly so, that the physician-patient relationship is the key to treatment. The clinician must refrain from being didactic or moralistic, but rather must be a sympathetic and interested listener, for the most important thing is to understand the patient's problems. Psychiatric consultation is indicated in deeply rooted complexes where special methods are necessary to uncover the cause; however, the vast majority of these problems are within the domain of the average physician.

With reassurance, genuine interest and understanding qualities, the physician will be met with a willing patient who will air his conscious problems. At this point if it is explained to the patient in understandable, illustrative ways how the mechanism of emotional tension can actually produce all his symptoms, he will be greatly relieved. Psychotherapeutically it must be emphasized that:

1. Emotional illness is just as important as pneumonia or a broken leg, though not as dramatic, but requires a longer time and much understanding to cure.

2. Everyone has emotional reactions but it is only when this reaction reaches beyond a certain threshold or a certain tolerance limit that symptoms begin to appear. The patient then becomes relieved and regains his self-esteem.

3. The patient's symptoms are not imaginary but just as real as fever and cough and that they are produced by nervous impulses but at the same time, though they may appear organic they are only due to deranged function. He must be convinced that the freely given advice of "pull yourself together" and "nothing anyone can do" is wrong and that he can really be helped.

4. The symptoms of tension state have nothing in common with mental illness, even though at times he felt like he was "losing his mind." He will be greatly relieved with this explanation because it is lurking in the back of his mind.

5. Symptoms are produced by nervous tension and are things that happen normally to the body when an acute danger exists, such as palpitations of the heart, turning pale, feeling weak, etc.

6. With every thought and action we have two component parts: reason and feeling. Both enter into every one of our thoughts and actions. In the last analysis an adjusted personality is one wherein reason always predominates over the feeling that is associated with the act or thought. If the reverse is true, tension state develops and finally we go beyond our threshold of tolerance and symptoms are made manifest.

(b) **Drug Therapy** — Calcium bromido-galactogluconate—Intravenous injections of 10 cc. of this drug is given once weekly for six to eight injections, then every 10 to 14 days for an additional six injections. The choice of this drug is made for the following reasons:

1. The patient becomes convinced of the physician's diagnosis of his illness because of the marked relief he will experience from tension symptoms. His confidence is gained. The effect may last 3 to 5 days usually at the beginning. He will state that he rests better, does not feel as tired and sleeps better.

2. It is a safe drug with no untoward reactions. It is contraindicated only in diseases where lithiasis is a complication. The warm feeling that permeates the entire body has a psychologic effect on the patient. There is no associated slowing down of mental activities.

3. Physiologically, calcium not only enhances the action of the bromine molecule but also acts as an antagonist to sodium and helps increase the threshold of tissue response to stimuli.

4. The injections are given purposely at a longer interval than the recurrence of symptoms in order to impress the patient that the injections only aid in conjunction with his understanding of the problems involved and are not to be regarded as a cure per se.

5. The patient feels that at last someone is doing something for him besides armchair consultations. Thus he becomes amenable to psychotherapy, as a calm mind is more receptive to reason than a troubled, anxious one. It gives an opportunity to the busy physician to see his patient several times and evaluate his responses, rephrase the patient's remarks and guide, not

instruct, his own thinking processes to therapeutic channels—put him, so to speak, back on the right road.

THERAPEUTIC RESULTS

Prognosis can be facilitated by dividing tension state into four types:

Group One: Patients in this group are aware of the underlying causes of their illness. It is the reassurance of the physician they seek that stressful situations can account for all of their symptoms. The patient is glad when he is told that the pounding he feels is not due to heart disease but rather to emotional factors involved. The majority of these patients have phobias of serious disease.

Group Two: Patient is unaware of any causative element that may produce his illness, and rightly so, for in this group are many patients who are mildly psychoneurotic. They are the perfectionistic type who drive themselves to exhaustion in order to do their work to perfection to the last detail. I remember the young lady who told me that after going to bed she kept worrying about her dress, which was hanging in the closet, to the point where she turned on the lights, and went to the closet to see if the ironed crease in her dress was hanging just right. These patients are dominated by a tyrannical conscience—(of course, they make excellent workers)! They want ample proof from the physician that he really diagnosed their illness correctly. They are "doubting Thomases." In this group also falls the hypersensitive individual who goes to pieces if something goes wrong in his environment. Response here is good but time-consuming.

Group Three: The patient in this group makes the least satisfactory response because he is the psychoneurotic with fixed hysterias, anxieties or depressions. His family background reveals such episodes as institutionalized uncles, suicides, siblings with "nervous breakdown," etc. He is the individual of whom Alvarez says "the Great Contractor put poor materials in his structure." These are the patients who frequently wander from one physician to another, who have had shock therapy and who border on being psychotic. These patients are best treated by a psychiatrist. They usually respond poorly to any type of therapy.

Group Four: The symptoms of the patient in this group are characterized by similarity to organic disease. While anatomically not conforming entirely to any particular organic disease, they can well prove pitfalls in diagnosis. Their emotional conflict is not on a conscious level. The physician here is taxed to no end of deliberations as to whether or not there is an underlying physical cause or an underlying emotional conflict. These people therefore warrant "much listening to" and repeated search for the unconscious stressful situations and, at the same time, diligent physical search beyond the ordinary physical examinations. A neurotic backache can be tuberculosis of the spine. A spastic colon pain may prove to be renal lithiasis and a pinching precordial pain may turn out to be bronchiogenic carcinoma. The response to treatment is excellent provided that a correct diagnosis is made.

RESULTS

A group of 208 patients (51 male, 157 female) was treated, employing this combination therapy. The patients all presented symptoms of "tension state." A variety of symptoms were encountered. Seventy per cent showed good response, 22 per cent fair response, and 8 per cent poor response.

SUMMARY

Tension state is a very common illness. It requires time and applied knowledge on the part of the physician. A two-fold method is outlined, consisting of psychotherapy and intravenous calcium bromido-galactogluconate. It is emphasized that unless certain diagnostic criteria are adhered to, much time will be wasted unproductively. Medication is given to convince the patient of his illness, gain his cooperation, and make him amenable to psychotherapy. The latter can be fruitful only when the patient: (1) gets an insight into the mechanism producing his illness; (2) his phobias and misapprehensions are dispelled and (3) when either the personality is adjusted or the environment manipulated.

The outlined therapy is not difficult and is well within the armamentarium of the general practitioner.

To facilitate prognosis, four groups of patients with tension states are described.

The neurotic presents a special problem to the physician requiring a greater understanding on his part. But the end results are very gratifying. As Plato has said: "The goal of life is happiness"—and aiding him to reach that goal is precisely what the physician does for this type of patient.

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Dysphagia in Polio

Acute poliomyelitis, bulbar type, quickly presents a child who is having increasing dysphagia, nasal voice and the accumulation of saliva and mucus in the throat. Attempts to drink fluids causes coughing and choking. These symptoms are usually followed by coma, respiratory arrest, etc. The use of the respirator, early tracheotomy, and supportive care are important.—Donald S. Bolstad, M. D., Jack S. Campbell, M. D., Detroit; *J. Michigan State M. S.*, 52:187, February, 1953.



A Case Record

From The Cincinnati General Hospital

Edited Under the Auspices of the Ohio Society of Pathologists

Robert Ritterhoff, M. D., President

Presented by Morton Hamburger, M. D., and Pearl M. Zeek, M. D. Edited by E. A. Gall, M. D.

PRESENTATION OF CASE

A 62 YEAR OLD WHITE salesman was admitted to the hospital complaining of dyspnea and died on the following day.

The patient was disoriented and delirious and the history was obtained from his wife. He had suffered from shortness of breath with exertion intermittently for the past eight years. While on a trip to Iowa four weeks prior to entry he suddenly became markedly dyspneic and was sent back to Cincinnati by plane. He went to bed, though he was up and about on occasion. The dyspnea persisted, orthopnea ensued and two weeks before admission became more severe. An electrocardiogram made by his physician was said to show "myocardial damage."

There had been attacks of paroxysmal nocturnal dyspnea for the past month. Three nights before entry, ankle edema became apparent for the first time. On one occasion, following the intravenous administration of a mercurial diuretic, there was a chill. The patient felt weak, sweaty, anorexic and nauseated. There was no pain. On the night before admission he had a severe shaking chill and developed mental confusion. For about two weeks he had been taking digitalis prescribed by a physician. There had been an unexplained weight loss of 24 pounds during the preceding year. In the Receiving Ward both pulse and blood pressure were imperceptible. The apical rate was 96 per minute.

Physical Examination: The patient was well developed, fairly well nourished, garrulous and disoriented on occasion and was intermittently stuporous. He was propped up in bed and though breathing rapidly (respirations 38 per minute) seemed to have little difficulty in breathing when awake. While stuporous, however, his breathing was stertorous though regular in character. Neck veins were distended. Pupils were pinpoint and reacted neither to light nor accommodation. There was cyanosis, more marked in the acral parts. The skin was warm and sweating. Temperature, 100°. There was a sweet fetid odor to the breath.

Both sides of the thorax and the diaphragm moved symmetrically. The posterior chest was not examined but there was no dullness anteriorly. There were palpable rhonchi and many coarse rales were audible. The cardiac apical impulse was forceful but diffuse. Maximal thrust was easily palpable in the sixth interspace at the anterior axillary line. Sounds were rapid, regular and loud. A very loud systolic murmur was audible all over the precordium. P_2 was louder than A_2. No thrill or friction rub was felt. Pulse, 108 per minute; blood pressure, 90/78.

The abdomen was moderately distended and tympanitic. The liver edge was sharp, smooth, tender and was four fingerbreadths beneath the costal margin. There was 2 plus edema of the ankles and sacral region. Neurological examination was unrevealing. Venous pressure was 200 mm. of water.

Laboratory Findings: Red cells of the blood numbered 5.3 million with 14.5 Gm. of hemoglobin; the white cell count was 27,800 with 94 per cent neutrophils. The urine contained 1 plus albumin and in the sediment were seen occasional red and white cells. Coagulation time was 2½ min. at entry and 5 min. ten hours later. The blood urea nitrogen was 47.5 mg. per 100 cc. and the serum protein was 6.2 Gm. A prothrombin con-

centration on the day of entry was 17 per cent (29 sec.). An electrocardiogram showed a rate of 100; PR, 0.23 sec.; QRS, 0.08 sec. T 1 and T 2 showed low voltage, T 3 was inverted. ST 2 and 3 were depressed.

Roentgen Findings: A portable chest film was not considered satisfactory though the transverse cardiac diameter appeared enlarged. The lower two-thirds of the right lung showed an extensive density which appeared more marked on the right base. Some lung markings could be visualized through this density. A similar but much less extensive infiltrate was present in the region of the left hilum. The left base was not visualized because of artefact. The apices were clear.

Hospital Course: The patient was treated supportively, receiving aminophylline, morphine, papaverine, and oxygen by nasal tube. An intravenous infusion of plasma was discontinued because of manifestations of pulmonary edema. Heparinization was instituted, four doses being administered in 12 hours (total amount, 180 mg.). His temperature did not rise above 100.5° F. and the highest blood pressure reading obtained was 96/80. The patient took fluids well, as offered, but there was no indication that he voided save for the initial sample examined in the laboratory. On the morning after admission he became markedly dyspneic, cyanotic and his blood pressure was unobtainable. Despite the administration of stimulants he lapsed into coma and expired about 45 minutes later.

CLINICAL DISCUSSION

Dr. Morton Hamburger: This is the case of a 62 year old salesman who during the last eight years of his life suffered from slowly progressive heart disease. Four weeks before admission he suddenly became worse while out of town, and finally on the day before death he was stricken by an overwhelming catastrophe which quickly cost him his life. The differential diagnosis revolves around two problems: first, the diagnosis of the chronic illness which caused his intermittent dyspnea on exertion for eight years, and second, the events which immediately preceded his death.

The symptom of dyspnea on exertion usually indicates cardiac disease, though chronic pulmonary insufficiency due to emphysema or other chronic lung conditions which diminish the vital capacity may be the sole cause of this symptom. The sudden onset of dyspnea, so severe that return from Iowa to Cincinnati by plane became necessary, suggests either that the patient developed a spontaneous pneumothorax or that his heart disease became worse. That this symptom was almost certainly due to heart disease is indicated by the subsequent appearance of paroxysmal nocturnal dyspnea—the symptomatic trademark of cardiac insufficiency. When to this is added the later development of ankle edema, the diagnosis of heart disease is established.

NOCTURNAL DYSPNEA

Now, what kinds of heart disease are likely to cause paroxysmal nocturnal dyspnea in a man of 62? The most common are sclerosis of the coronary arteries and cardiac insufficiency associated with long-standing hypertension. This symptom is common also in syphilitic heart disease with aortic insufficiency, and when aortic insufficiency is present one always considers the possibility of aneurysm. It is also seen in rheumatic heart disease with mitral stenosis. What evidence is there for any of these?

It is likely that a traveling salesman had had blood pressure measurements made between the ages of 50 and 60, and since his wife apparently volunteered no information about pre-existing hypertension, one can assume that this condition probably did not exist. As to syphilis, there is no suggestion in the protocol that a serological test was made. One must consider in addition the possibility that this patient suffered from stenosis of the aortic valve, since three of his physical findings are compatible with this diagnosis. These are an apical impulse in the sixth interspace in the anterior axillary line, a loud systolic murmur even though no comment is made about the presence or absence of transmission to the neck, and second aortic sound which is less loud than the pulmonic sound in a man this age.

Let us consider the events that led up to his death. The sudden dyspnea in Iowa followed by the cardiac symptoms reported and the nonspecific electrocardiogram suggest that failure of a weakened myocardium was precipitated by some undisclosed event. Despite the absence of pain, one would immediately suspect acute myocardial infarction, but the report of the electrocardiogram militates against this.

The final catastrophe apparently came on with dramatic suddenness. Though still there was no pain the patient suffered a severe shaking chill, developed mental confusion and went into shock. When seen in the Receiving Ward his temperature was 100, presumably by mouth. The pulse was 108. The respirations were rapid, and the blood pressure was 90/78. The patient was sweating but the skin was warm. Cyanosis of the extremities was noted. The venous pressure was elevated to 200 mm. of water. The anterior chest was noisy and the protocol suggests that the patient appeared to be too sick to permit examination of his lung bases.

PHYSICAL FINDINGS

As previously mentioned, the heart was either greatly enlarged or pushed to the left, but there is nothing in the physical examination to

substantiate the latter possibility. It is noteworthy that the heart sounds were described as loud, that the systolic murmur was described as very loud, and that P_2 was louder than A_2. It is unfortunate that no description of the peripheral pulses appears in the protocol. Enlarged, tender liver and edema of the ankles are evidence of cardiac failure.

Some of the laboratory signs are helpful diagnostically. Though the patient had chills, a white blood cell count of 27,800 and a loud systolic murmur, no blood culture was made. The moderate elevation of blood urea nitrogen is compatible with heart failure. Except for the prolonged PR interval, which could have been due to digitalis, the electrocardiogram was apparently not specific. The roentgen film showed an extensive density in the right lung base.

The brief course in the hospital was marked only by rapid downhill progress. The use of anticoagulants shows that thrombosis was considered to be a major part of his troubles.

POSSIBILITIES

How is one to put all of this together? The conditions which might have been responsible for the patient's terminal illness include:

(1) Myocardial infarction either associated with a thrombus in the coronary artery or possibly an embolus from a bacterial vegetation on the aortic valve. Though myocardial infarction occurs in the absence of pain and in the absence of electrocardiographic change, it would be unlikely that both of these signs would be absent at the same time.

(2) Rupture of syphilitic aneurysm into the pulmonary artery. This also finds no support in the protocol.

(3) A dissecting aneurysm of the aorta. Here too the absence of pain does not completely rule out the diagnosis though the lack of a history of pre-existing hypertension or of any description of peripheral vascular phenomena makes dissecting aneurysm highly unlikely.

(4) Pulmonary embolism with infarct. Many things point to this possibility. They are the shadow at the right lung base, the loud P_2 and increased venous pressure, the sudden onset of shock and the presence of a systolic murmur. Chill is uncommon in pulmonary infarction, and the white cell count is higher than one ordinarily sees.

One cannot read this protocol without considering the possibility of acute bacterial endocarditis. The chill, leukocytosis and loud systolic murmur suggest acute endocarditis. However, there were no major or minor embolic phenomena, and the history hardly suggests this disease. The appearance of the x-ray, the character of the respirations, the chill and the leukocytosis are all compatible with lobar pneumonia, but the patient died very quickly for such a condition and I do not believe it a likely possibility.

In conclusion I think the most likely diagnoses are as follows: In explanation of the terminal event I suspect a large pulmonary infarct. I do not think the patient had acute myocardial infarction. The chronic heart disease is best explained on the basis of gradually progressive diffuse myocardial fibrosis secondary to arteriosclerosis of the coronary arteries and/or stenosis of the aortic valve.

CLINICAL DIAGNOSIS

1. Pulmonary infarction, terminal.
2. ? Coronary arteriosclerosis with diffuse myocardial fibrosis. ? Aortic stenosis.

CLINICAL DISCUSSION

Dr. Philip Wasserman: How do you account for the low prothrombin time?

Dr. Hamburger: I cannot. Perhaps it was a laboratory error. Dr. Iglauer, do you think it possible to have an electrocardiogram like this with pulmonary infarction and acute cor pulmonale?

Dr. Arnold Iglauer: Yes, I do. It is quite possible to have an acute pulmonary infarction without diagnostic changes in the tracings.

Dr. Julien E. Benjamin: What do you suppose caused the temperature elevation?

Dr. Hamburger: It never was elevated above 100.5° and I don't think it very important. I am more disturbed by the level of the leukocytosis, and it is possible that both the fever and the white count indicate the presence of pneumonia.

Dr. S. W. Whitehouse: I saw this patient during life on several occasions over a period of years. His systolic blood pressure varied between 90 and 119 mm. and never rose above those levels. His Kahn test was negative. During the time that I saw him his complaints were mainly pain in the left chest and shoulder and dyspnea on exertion. The symptoms were always relieved with appropriate cardiac therapy.

Dr. M. A. Blankenhorn: I believe it is unsafe to assume that the term "nocturnal dyspnea" necessarily indicates the specific paroxysmal syndrome. It may be a spurious label unless suitably documented by facts concerning its manifestations.

ANATOMIC DIAGNOSIS

1. Myocardial degeneration, anoxic, acute and chronic.
   - A. Aortic valvular stenosis, nodular calcareous, advanced.
   - B. Coronary arteriosclerosis, advanced.
   - C. Mural thrombosis, left ventricle, old and

recent; extension into Thebesian veins with multiple occlusions, terminal.

D. Myocardial infarcts, miliary, old and recent.

E. Generalized arteriosclerosis, advanced, with extensive mural thrombosis of abdominal aorta and branches.

2. Chronic bronchitis and pleuritis; pulmonary arteriosclerosis, marked.

PATHOLOGICAL DISCUSSION

DR. PEARL M. ZEEK: The important pathological changes in this case were caused by a combination of two disease processes, coronary arteriosclerosis and aortic valvular stenosis, each of which commonly decreases the blood supply to the myocardium. In this case death was caused by the resultant myocardial insufficiency.

The heart weighed 485 Gm., the moderate increase in weight being due to hypertrophied left ventricle, which was 20 mm. thick. The heart valves were essentially normal except the aortic valve, which was markedly thickened by fibrous tissue and calcified nodules. The cusps were distorted and fixed in a condition of apposition, producing a slit-like orifice which would admit only a 2 mm. probe. When at autopsy a valve such as this is found, without other valvular or myocardial disease, the heart usually weighs over 600 Gm. In this case the degree of myocardial hypertrophy was limited by concomitant coronary insufficiency.

The myocardium presented the usual small scattered areas of anoxic degeneration associated with marked aortic stenosis and caused by the decreased blood flow into the coronary arteries. In addition there were small old and recent myocardial infarcts. In some sections the two types of lesions were so numerous and overlapping that very few recognizable myocardial fibers remained. Such an area in the apex of the left ventricle was capped by an organizing mural thrombus which showed recent propagation into several Thebesian veins, the acute occlusion of which probably caused the terminal myocardial insufficiency.

In this case life was probably prolonged for a considerable time by nourishment reaching the myocardial cells through the Thebesian veins. Decreased coronary blood flow together with increased left intraventricular pressure favored the compensatory development of Thebesian venous circulation.

The coronary arteries of all sizes were markedly sclerotic, many being almost completely occluded, not by thrombi, but by slowly developing atherosclerosis with calcification. Also, some of them presented concentric rings of fibrous tissue in their adventitia, suggestive of healed rheumatic lesions. However, unequivocal rheumatic stigmata were not found. Therefore in this case, as in many other cases of aortic stenosis, one can neither rule out nor prove the role of rheumatic fever in the causation of the aortic valvular lesions.

Associated with the severe degeneration of the myocardium there was marked dilatation of the left ventricle and extensive chronic and acute passive congestion of the lungs and abdominal viscera. The marked venous stasis in the gastric mucosa had led to petechial erosions and there were fresh blood clots in the gastric contents. There was slight pulmonary edema and about 100 cc. of clear fluid were found in each pleural cavity.

The ascending aorta presented only minimal atherosclerosis as is common in cases of aortic valvular stenosis. The abdominal aorta, however, was markedly sclerotic with lipid deposition in the intima, thinning of the media and occlusion of about two-thirds of the lumen by an organizing mural thrombus. This clot extended from the level of the renal arteries throughout the remainder of the aorta and protruded into the left renal and both common iliac arteries. The fact that no complete occlusion was found indicates that this clot was probably not embolic in origin.

A postmortem blood culture gave growth to Aerobacter aerogenes, which was thought to be a contaminant since no lesions suggesting septicemia were found in the microscopic sections.

The lower pulmonary lobes appeared to be consolidated at autopsy, but no pneumonia was found microscopically. The alveolar sacs were loaded with "heart failure" cells and erythrocytes indicating marked acute and chronic passive congestion. The bronchial walls were thickened and the lumens filled with mucus. The small and medium-sized branches of the pulmonary arteries were markedly sclerotic with narrowed lumens. This finding is common in rheumatic heart disease but is usually associated with mitral stenosis.

The findings in this case add credence to the belief that in order to become hypertrophied the myocardium must have an adequate blood supply.

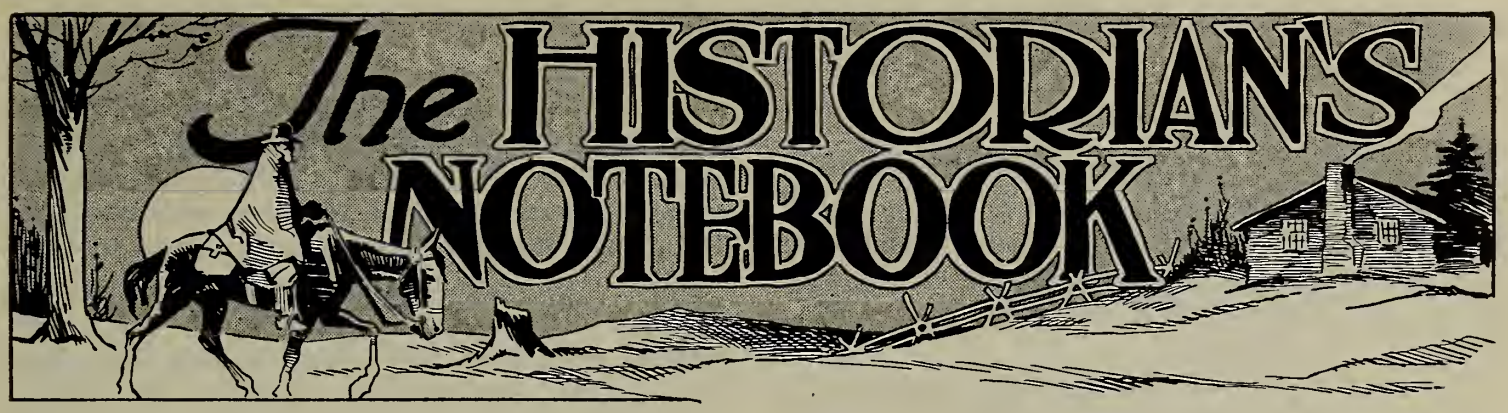
GENERAL DISCUSSION

DR. BLANKENHORN: Had there ever been any episode of syncope to suggest cerebral anoxia?

DR. WHITEHOUSE: The patient became unconscious during the episode which occurred in Iowa, but no other phenomena of like nature were ever noted to my knowledge.

DR. BLANKENHORN: Often syncope may be the only symptom indicating the development of aortic stenosis. . . . With what frequency does one see marked coronary sclerosis in association with aortic stenosis?

DR. ZEEK: I do not know of any actual figures on the incidence of this combination of lesions.



Medical Education in Ohio

FREDERICK C. WAITE, Ph. D.

MEN have been prepared for the practice of medicine in Ohio under three systems: by private instruction under a practicing physician, by institutional instruction in a medical college, and by combination of these two methods. Private instruction by a practicing physician was related to the system of apprenticeship in the crafts and was called the preceptorial system before 1800.

THE PRECEPTORIAL SYSTEM

The traditional period of instruction was three calendar years during which the student received both didactic and clinical instruction from his preceptor and upon completion of this length of study received a certificate of proficiency. He became a legal practitioner either by filing this certificate in a court of record or by passing examinations given by the censors of a medical society, which issued a license.

The preceptorial system varied widely in efficiency depending upon the capability and general education of the student and upon the education, experience, and teaching ability of the preceptor. It was begun in Ohio soon after the first permanent settlement at Marietta in 1788 where there were three resident physicians before 1800.

THE COMBINED SYSTEM

The combined system was begun when the first medical college in Ohio was founded in 1819. A student who, in the three years of study under a preceptor, attended two sessions in a medical college, wrote a dissertation, passed examinations, and had reached the age of 21 years received the degree of Doctor of Medicine. Many students attended only one session in a medical college and lacked a degree, but nevertheless practiced after securing a license from a medical society. The exhibition of a diploma attesting possession of the degree of Doctor of Medicine to the censors of a medical society brought a license to practice without further examination throughout the nineteenth century.

The two members of the combined system were supplementary in their instruction of students. The student received the greater part of his didactic instruction at the medical college and the greater part of his clinical instruction from the preceptor. A graduate in medicine in Ohio between 1850 and 1870 had spent 32 weeks in medical colleges and 124 weeks, or nearly 80 per cent of his entire period of study of medicine, under his preceptor. There were frequent references to the science of medicine but the emphasis in teaching was on the art of medicine.

The preceptorial system continued in Ohio in the combined relation until near the end of the nineteenth century. Medical colleges in Ohio about 1890 began to omit names of preceptors in the lists of students published in their catalogues and only a few continued to print the names of preceptors after 1900. Thus the preceptorial system existed in Ohio, either alone or in the combined relation, during a little more than one hundred years.

There were three groups of physicians in Ohio in the nineteenth century: those who held the degree of Doctor of Medicine, those who had attended one session in a medical college, and those who had never attended a medical college. The proportion in the first group steadily increased as the century progressed and the pro-

The Author

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Read before the joint meeting of The American Association of the History of Medicine and The Ohio Academy of the History of Medicine at Columbus, Ohio, April 11, 1953.

portions in the second and third groups correspondingly decreased.

MEDICAL COLLEGES

The story of institutional medical education in Ohio extends over 134 years and is complicated by many factors. Time permits only a fragmentary sketch and therefore discussion of the conditions and agencies that influenced each of the steps must be omitted.

The first institution for teaching medicine in Ohio was the Medical College of Ohio in which instruction was begun with four professors in 1819 and has continued without interruption under four different official names to the present day. It was the thirteenth medical college founded in the American Colonies and the United States and the second west of the Allegheny Mountains, being preceded in that area by only the Medical Department of Transylvania University at Lexington, Kentucky. It has conferred 7,230 degrees of Doctor of Medicine through 1952 which is more than 31 per cent of the degrees granted by all the regular colleges of the state.

Ohio has had 57 differently named medical colleges. This multiplicity of institutions arose largely from dissensions in medical faculties followed by withdrawal of a faction to found a rival institution. Twenty-five of these medical colleges were located in Cincinnati, 15 in Cleveland, eight in Columbus, three in Toledo, and one each in six smaller cities and towns in the state. Four of these were for women only and four others were fraudulent. The years of operation under one official name varied from 1 to 77. Only four operated under one name for more than 50 years while 12 others continued under one name from 25 to 49 years. Eleven of them continued under one name fewer than five years. The largest number in any one year was 18 in 1890-1891. This number was reduced to six by 1910 and to the present three in 1939.

These 57 differently named medical colleges included 29 that were regular, ten that were homeopathic, seven that were eclectic, four that were nondescript, giving only part of the subjects usually taught, and seven that were botanic or physiomedical. The name "botanic" was supplanted by the designation "physiomedical" in 1850.

These institutions were terminated by three methods. Twenty-five became extinct without any legal successor, 17 changed their official names, and 12 were merged with other existing medical colleges, making a total of 54. Three are still in existence.

One medical college had no charter and for two others the charter did not give the power to grant degrees; 54 had the authority to confer the degree of Doctor of Medicine, either under independent charters granted by the legislature or under the charters of colleges of arts and universities with which the medical colleges were affiliated.

The number of teaching organizations was fewer by 21 than the 57 differently named institutions because of changes of official names with continuation of the same teaching organizations. The oldest homeopathic medical college in Ohio changed its official name seven times. These 36 teaching organizations included 17 that were regular, five that were homeopathic, five that were eclectic, five that were botanic and physiomedical, and four that were nondescript. All of the last group were fraudulent.

MEDICAL DEGREES CONFERRED IN OHIO

I published in *The Ohio State Medical Journal* in 1950 a paper under the title of "Ohio Physicians of the Nineteenth Century, a Statistical Study" in which I tabulated a total of 19,881 medical degrees conferred in Ohio through 1900. These included 380 honorary degrees and 148 *ad eundem* degrees, leaving 19,383 degrees in course. The degrees were all that of Doctor of Medicine with two exceptions. One institution granted six degrees of Doctor of Homeopathy in 1850 and a homeopathic college conferred a few degrees of Doctor of Obstetrics and Gynecology upon women.

The total of graduates in the nineteenth century which I published in 1950 was incomplete. It included none of the graduates of one eclectic medical college that existed during four years nor of another that operated during three years. Only partial statistics were included for a third eclectic medical college that existed for 20 years. The figures omitted because of incomplete available records represent about 100 eclectic medical degrees.

The available records of the number of graduates in five botanic and physiomedical institutions are too fragmentary to permit a rational estimate and only a conjecture can be given. Some were of short life. Others alternated prosperous and decadent periods and two were temporarily suspended for a few years. Attendance was meager and the majority of those enrolled did not remain for a second session required to get a medical degree. About 100 small classes were graduated in these five botanic and physiomedical colleges. My conjecture is that they conferred not fewer than 500 nor more than 800 medical degrees.

The tabulation of medical degrees conferred in Ohio in the nineteenth century has been extended through 1952 and gives a total of medical degrees granted, from 1821 to 1952 inclusive, by regular medical colleges as 23,096, by eclectic medical colleges as 4,702, and by homeopathic institutions as 2,825 making a total of 30,623 medical degrees of which record has been found. To this number should be added my conjecture of about 100 unrecorded eclectic degrees and of

500 to 800 botanic and physiomedical degrees, making a grand total of approximately 31,400 valid degrees conferred in Ohio through 1952. No basis has been found for making even a conjecture of the number of degrees granted by four fraudulent institutions, each short-lived and all in the final quarter of the nineteenth century.

The definite figures just given are complete for regular medical colleges except for the final class of one small institution which closed in 1896. Not more than 12 were in this class. The figure for homeopathic medical colleges is believed to be exact and the figure for eclectic institutions is short of the actual number by about 100 because of incomplete records.

THE CURRICULUM

I have read more than 800 issues of catalogues of medical colleges of Ohio in the nineteenth century to secure information on the progress of the amount and character of medical teaching in the state. The language in these publications is often so indefinite that it is uncertain whether a statement as to a step of progress represents a hope, a proposal to become effective at a future date, or a condition actually in operation. These catalogues until about 1890 contain many claims of excellence and superiority as propaganda to attract students.

The first factor of progress was in the length of teaching sessions in the medical colleges. The usual length throughout the country was 12 weeks prior to 1820. This was increased to 14 weeks in the 1830's. The first record I have found of a session of 16 weeks in Ohio was in one regular medical college for the session of 1843-1844. Most of the regular medical colleges were conducting sessions of 16 weeks before 1850.

A national Medical Teachers' Association was formed at Cincinnati in 1867. It made four salient recommendations: that a standard preliminary education should be required of all students, that the length of the session should be increased to 24 weeks, that three sessions of attendance should be required before a medical degree was conferred, and that the course should be graded. These actions influenced the progress of medical education in all parts of the country although response to the last two of them was delayed in Ohio until 21 years later.

The first response in Ohio was by two regular medical colleges in 1870 when they began giving sessions of 20 weeks which were required and a following optional spring term of eight or ten weeks. One regular medical college extended the required session to 24 weeks in 1877. No further marked increase came until one regular medical college began giving a required session of 30 weeks in 1894-1895 by combining the required session and the optional spring term. Vacations at Christmas time appeared shortly before 1890. The first session of 32 teaching weeks in Ohio was begun in one regular medical college in 1903-1904.

The American Medical Association before 1850 condemned the plan of giving two sessions and graduating two classes within one calendar year. No regular or homeopathic medical college in Ohio adopted this policy but the botanic, physiomedical, and eclectic institutions used this plan and therefore could not increase the length of sessions beyond 20 weeks until 1895, when the plan was abandoned.

ATTENDANCE REQUIREMENT

The next factor of progress was increase of the number of sessions required to be attended in a medical college before granting the degree of Doctor of Medicine. The standard in Ohio during 69 years was study of medicine during three full calendar years and attendance at two sessions in a medical college before the degree was conferred, except that graduates of colleges of arts were required to study medicine during only two calendar years.

The first requirement of attendance at three sessions before receiving the degree in Ohio was in one regular medical college for the class entering in 1888. Other institutions soon adopted the plan of three sessions. Three regular medical colleges in the state inaugurated the course of four sessions for classes entering in 1895.

No medical college in Ohio had any requirement of preliminary education until 1875 when several institutions announced that an examination would be required of all applicants who were not graduates of a college of arts, an academy, or a high school. The first definite content of these examinations was published by one regular medical college in 1879 and approximated the amount of education that would be given in two years in an academy or high school. This was gradually increased and most medical colleges in Ohio by 1896 required as a minimum for entrance the graduation from an academy or high school giving a course of three years, or establishment of an equivalent by examination. A wide advance came in one regular medical college in the state when it required completion of three years in a college of arts for the class entering in 1901.

LABORATORY COURSES

The only required laboratory instruction in Ohio prior to 1888 was the rapid dissection of the human cadaver, either under a preceptor or in a medical college. These dissections in the medical colleges were usually completed in fewer than thirty hours of work by the student. The giving of optional laboratory courses in chemistry was begun in one regular medical college in 1868 and extended to many other institutions in the next 20 years. The medical colleges in the early 1870's began to give an optional spring

term of eight or ten weeks following the required regular session and the optional laboratory work in chemistry was taught in this spring course.

One regular medical college inaugurated required laboratory courses in chemistry, histology, and physiology in the session of 1888-1889, the first required laboratory work in any medical college in Ohio other than dissection. Laboratory courses in bacteriology and pathology were first required in one regular medical college in the session of 1893-1894 and several other institutions adopted this step of progress between 1894 and 1897.

The curricula of all medical colleges in Ohio were repetitive until 1888. Students attending their first session and those attending their second session sat together in the amphitheater to listen to didactic lectures. If a student returned to the same medical college for his second session he heard the same lectures as in his first session unless a professor had rewritten his lectures, a rarity, or there had been a change of professors, which was common.

INAUGURATION OF GRADED COURSE

The question of a graded course was discussed during 20 years, with few advocates, before any action was taken in Ohio. One regular medical college inaugurated a required graded course of three years for the class entering in the fall of 1888. Sixteen other medical colleges in Ohio adopted the graded course of three years between 1890 and 1894. Two regular medical colleges began a graded course of four years for the class entering in the fall of 1895. All regular medical colleges in the state were on this basis before 1900. The graded course was the leading feature of the great improvement in medical education in Ohio in the 20 years from 1880 to 1900.

The advance in medical education in Ohio in the first half of the twentieth century has included incorporation of all regular medical colleges into the universities, the extinction of all sectarian medical colleges, and large increase in the number of full-time professors. The first full-time professor in a medical college in Ohio was a professor of physiology in one regular medical college in the session of 1893-1894. Laboratory teaching has been much extended and improved, equipment augmented, and the facilities for clinical teaching greatly increased. Didactic instruction has been replaced by practical work to a considerable degree.

CLINICAL INSTRUCTION

Medical Colleges in Ohio gave meager attention to clinical teaching prior to 1850, leaving that phase of the training of medical students to the preceptors. The first record that I have found of clinical teaching scheduled each week is in the session of 1843-1844 when one of the seven medical colleges in Ohio, a regular institution, began to give one clinic each week in medicine and another in surgery. This replaced the giving of occasional clinics in prior years. The giving of regular scheduled clinics each week was extended to many medical colleges in the state prior to the Civil War but the amount given was not much increased in the regular session until the graded course came into operation. The optional spring course included considerable clinical teaching.

Each of the several steps of progress that I have mentioned was initiated by a regular medical college and other regular institutions soon followed, while the sectarian medical colleges lagged on each step, on some of them for as many as ten years.

MEDICAL EDUCATION OF WOMEN IN OHIO

One regular medical college in Ohio graduated six women in the 1850's. No more women were graduated in a regular medical college until 1873. Only one regular medical college was admitting women in 1880. Five more regular institutions adopted coeducation by 1890. Three regular medical colleges for women were founded between 1887 and 1896, with an average life of seven years.

The sectarian medical colleges began to admit women in 1850. The policy was suspended several times and accentuated after 1870. A homeopathic medical college for women existed in Cleveland from 1867 to 1871 with 17 graduates. The sectarian institutions urged women to enter with the result that the majority of women practitioners in Ohio in the nineteenth century were sectarians. A directory of all physicians in Ohio published in 1890 shows 73 per cent of the women practitioners at that time to have been sectarians.

All that I have written is factual except a few stated conjectures regarding numbers of graduates. I close with a personal opinion. Study of the catalogues of medical colleges in Ohio in the nineteenth century and comparisons at different dates has convinced me that at any given date the best medical instruction in the state was in the regular medical colleges, the second best in the homeopathic institutions, followed by somewhat inferior instruction in the eclectic medical colleges, and by grossly inferior teaching in the botanic and physiomedical institutions. The work in the four fraudulent organizations was by far the poorest.

Prevention of High Blood Pressure

In Plato's philosophy of old age he makes the comment: "He who is a calm and happy nature will hardly feel the pressure of age." One might add, "will hardly feel the high blood pressure of age."—Edward L. Bortz, M. D., Philadelphia, Pa.; *The Journal Lancet*, 73:93, March, 1953.

New Doctors' Draft Act . . .

Better Break for Physicians with Prior Service Provided for in New Federal Measure; Details of Law, Effective July 1, Are Enumerated

SHORTLY before this issue of *The Journal* went to press, Senate and House conferees of the U. S. Congress had agreed on legislation extending the provisions of the Doctors' Draft Act beyond July 1, 1953. It is practically certain that both houses will accept the conference committee bill and that a new version of the Doctors' Draft Act will be in effect by the time this issue reaches members of the Association.

MAIN PROVISIONS

Following are the principal provisions of the revised act, effective July 1:

The law is extended for a period of two years.

Special monthly allowance of $100.00 is authorized for physicians, dentists and veterinarians who volunteer for active duty.

Aliens may be commissioned and credit is given for cobelligerent service during World War II.

The national, state and local advisory committees will continue to function.

Commissions will be commensurate with the professional education, experience and ability of the physicians applying.

Four priority groups for the classification of physicians is retained.

CAN'T BE CALLED UP

No man with 21 months of prior service can be called during the two-year life of the act.

"Prior service" under the act means all active duty time since September 16, 1940, with no distinction between time served before and after completion of medical education in cases of Priority I and Priority II men. It does not include time spent in ASTP or V-2 training or time spent in military postgraduate service.

Priority II men with 17 months of prior service are to be transferred to Priority IV.

Physicians now on active duty who would not have been called had this measure been law at the time they were called are to be released within 90 days from July 1, 1953.

SCHEDULE OF REQUIRED SERVICE

The length of required service of those affected by the act is set forth in the following schedule:

If less than 9 months of prior service, 24 months of active duty required;

If 9 months of prior service but less than 12 months, 21 months of active duty required;

If 12 months of prior service but less than 15 months, 18 months of active duty required;

If 15 months of prior service but less than 21 months, 15 months of active duty required.

It is reported that there will be no July call up by Selective Service of physicians as plans had to be delayed pending enactment of the new legislation. The deficit may be made up through a heavier call in August.

Anesthesia Research Society To Meet in Quebec

The International Anesthesia Research Society will hold its 28th Annual Congress at the Chateau Frontenac, Quebec City, Canada, October 26-29. Dr. A. William Friend, 515 Nome Ave., Akron 20, is program chairman.

Dr. Friend and Dr. R. J. Whitacre, Cleveland, were scheduled late in June to meet in Brussels with European anesthesiologists to explore the possibility of forming some sort of international federation of national societies of anesthesiology in order to promote a more cohesive group.

Surgeons To Meet in New York

The 18th Annual Congress of the United States and Canadian Sections of the International College of Surgeons will open at the Waldorf-Astoria in New York on Sunday evening, September 13. Details may be had from the College at 1516 Lake Shore Drive, Chicago 10, Ill.

Seniors Oriented on Rural Practice . . .

State Association Spells Out the Advantages of Non-Metropolitan Practice to Senior Medical Students at O.S.U. for Second Year

THE second year of a project to interest more medical graduates in the practice of medicine in Ohio's rural areas was concluded May 13 with a dinner meeting held on the campus of the Ohio State University.

Sponsored by the Committee on Rural Health of the Ohio State Medical Association, with the cooperation of the Ohio State University College of Medicine, the Senior Class Cabinet, and the Student American Medical Association, the program involved a series of five lectures geared to acquaint senior medical students and their wives with general medicine as it is practiced in rural areas and small towns.

It is felt by the committee that if medical students are given a candid picture of rural general practice, with both advantages and disadvantages of life in rural areas, more medical graduates will consider this type of life following graduation from medical school and internship.

THREE SPEAKERS FROM THE FIELD

Serving as lecturers for this year were the following members of the Association's Committee on Rural Health: Dr. J. Martin Byers, Greenfield, chairman; Dr. Edmond K. Yantes, Wilmington; and Dr. V. R. Frederick, Urbana.

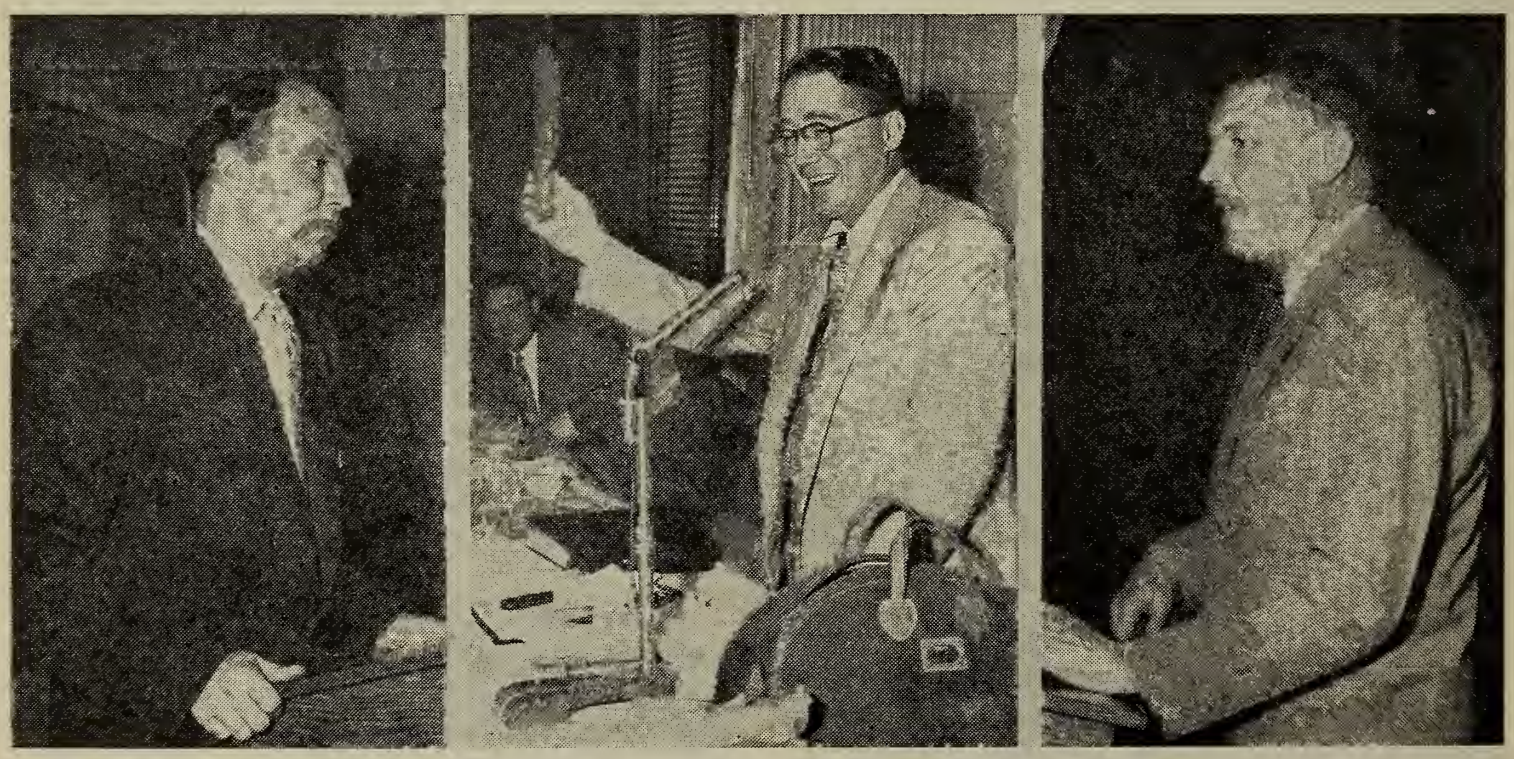
Guests of the Association at the final meeting in addition to the students and their wives were: Dr. Richard L. Meiling, treasurer of the Association, and associate dean of the College of Medicine; Mrs. Meiling; Dr. George Newton Spears, member of the Committee from Ironton, Mrs. Spears, Mrs. Byers, Mrs. Yantes, Mrs. Frederick, who spoke briefly, and Mrs. Frame, Mrs. Colburn, and Mrs. Smith, of the College of Medicine Staff.

Lectures were held April 8, 15, and 29, and May 6 and 13. Subjects covered included: "Selecting the Place to Practice"; "The Economics of General Practice"; "Hospital Connections and Emergencies"; "The Physician and His Community"; and "Types of Practice Encountered."

Details concerning the lecture arrangements were worked out by Dr. George H. Ruggy, junior dean of the College of Medicine, and Mr. Hart F. Page, Secretary to the Committee on Rural Health of the Association.

PART OF OVER-ALL PROGRAM

Other programs of the Association to encourage general practice in smaller cities and rural areas include the Ohio State Medical Association Rural Medical Scholarship, nearing its fifth year of operation; The Ohio State Medical Association locations service, which aids new physicians, returning medical officers and physicians desiring new areas; and continuing cooperation with the Ohio Rural Health Council and the farm organizations on rural health problems.



Here are three members of the State Association's Committee on Rural Health who passed on to senior medical students at Ohio State University their practical experiences in the field. Left to right are Dr. Edmond K. Yantes, Dr. J. Martin Byers, and Dr. V. R. Frederick. Dr. Byers punctuates his talk with a bit of levity to the tune of his duties as county coroner.



Senior medical students at Ohio State (and their ladies) are shown as they attended one of the series of candid talks on rural practice. Sponsors hope to achieve through this program a more equitable distribution of young doctors.

(See facing page for details)

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

A shift in procurement from blood plasma to serum albumin and plasma expanders is announced by Federal Civil Defense Administration, which says the change is due primarily to recent "satisfactory completion of extensive field experience with expanders." Stockpile goal is now two million units of plasma or other blood derivatives and five and one-half million units of plasma volume expanders.

* * *

Veterans Administration apparently is convinced that hospital insurance plans cannot be forced to drop "exclusion clauses," provisions which relieve the insurer of liability for payment to V. A. hospitals. One of the points at issue was the exclusion of payments to the V. A. for non-service connected cases.

* * *

A 69-page manual titled "Emergency Medical Treatment" has been published by the Federal Civil Defense Administration to help doctors and other civil defense casualty workers treat large numbers of victims in case of enemy attacks on U. S. cities. Available from Government Printing Office, Washington 25, D. C., for 25 cents.

* * *

Upon his retirement July 1, Rear Adm. Bertram Groesbeck, Jr., will be succeeded by Rear Adm. Leslie O. Stone as commander of Naval Medical Center. Latter's place as assistant chief of Bureau of Medicine and Surgery for professional and personnel affairs will be taken by Rear Adm. John Q. Owsley.

* * *

A new ruling by Bureau of Internal Revenue holds that physicians giving part-time services to industrial medicine are not employees of companies which engage them. Latter, accordingly, need not cover them under employment insurance or social security. Turnabout is the result of Federal court decision (Willard Storage Battery Co. v. Carey) which held that private practitioners who devote only a minority of their professional time to industrial medicine remain in self-employed category.

* * *

Federal Trade Commission announces a number of cases involving extravagant claims for drugs and devices: "Pruvo" (arthritis and neuritis) was tagged with a cease-and-desist order. Advertising claims for "Gallusin" (gall bladder trouble); "Lanacane" (acne); "Vitrex" (weight reducing); and Luden's cough drops will be modified as the result of agreed stipulations.

* * *

Recently returned from Korea and Far East, Colonel Robert L. Black, chief of Army Medical Service Corps, says his two-months trip produced ample evidence of Corps' efficiency in relieving medical officers of administrative chores so that they could devote themselves strictly to medical duties.

A.M.A. New York Session . . .

More Than 80 Ohioans Take Part in Meeting; McCormick Is Inaugurated To Head A.M.A.; House Takes Action on Many Vital Matters of Policy

AMONG the highlights of the 1953 Annual Session of the American Medical Association in New York City, June 1-5, were the inauguration of Dr. Edward J. McCormick, Toledo, as president of the A. M. A. for the ensuing year, and the appointment of Dr. George A. Woodhouse, Pleasant Hill, Ohio, to the Judicial Council of the A. M. A. for a five-year term.

The House of Delegates of the A. M. A. took important policy actions on veterans' medical care, medical ethics, osteopathy, intern training and a wide variety of subjects ranging from medical education to public relations.

Dr. McCormick took office at a special inaugural session of the House of Delegates and the membership at large in the Hotel Commodore on Tuesday, June 2. His inaugural address entitled "American Medicine's Report to the Nation," was recorded and broadcast over the ABC network the following evening.



EDWARD J. McCORMICK, M. D.

This is the first time that an Ohioan has held the Presidency of the A. M. A. since Dr. J. H. J. Upham, Columbus, served in that capacity in 1937.

Dr. McCormick is a Past-President of the Ohio State Medical Association and has served in numerous other official capacities from the local to the national level. His service included six years on the Board of Trustees of the A. M. A. before being named president-elect in June, 1952.

More than 80 Ohio physicians took part in the program, either in official capacities or as participants in the program. Approximately 500 Ohio doctors attended the meeting, not including members of physicians' families and persons in ancillary professions.

The New York meeting was the largest in the history of the American Medical Association, with the attendance reaching approximately 40,000, including nearly 18,000 physicians.

Delegates representing Ohio State Medical Association at the A. M. A. meeting were: Dr. Herbert B. Wright, Cleveland; Dr. C. C. Sherburne, Columbus; Dr. E. O. Swartz, Cincinnati; Dr. Carl A. Lincke, Carrollton; Dr. Richard L. Meiling, Columbus; Dr. George A. Woodhouse, Pleasant Hill; and Dr. Joseph Lindner, Cincinnati.

Dr. Paul A. Davis, Akron, represented the A. M. A. Section on General Practice in the House of Delegates.

Dr. Woodhouse, who was elected to The Council of the Ohio State Medical Association at the 1953 meeting of the Association in Cincinnati and who has served for many years as an Ohio delegate to the A. M. A., was appointed by Dr. McCormick to the Judicial Council of the national organization. The appointment was confirmed by the House of Delegates. The Judicial Council is one of the A. M. A.'s most important agencies.

Ohio at present is represented on five other councils of the A. M. A.

Dr. Carl A. Lincke, Carrollton, is a member of the Council on Scientific Assembly. Dr. Torald Sollmann, Cleveland, is chairman, and Dr. Joseph Hayman, Cleveland, is a member of the Council on Pharmacy and Chemistry. Dr. Robert A. Kehoe, Cincinnati, is a member of the Council on Industrial Medicine.

Dr. Richard L. Meiling, Columbus; Dr. A. A. Brindley, Toledo, and Dr. Herbert B. Wright, Cleveland, are members of the Council on National Emergency Medical Service. Dr. Carll S. Mundy, Toledo, is a member of the Council on Rural Health.

Dr. Maurice Levine, Cincinnati, is serving on the A. M. A. Committee on Mental Health.

MEDICAL CARE OF VETERANS

The A. M. A. House of Delegates gave unanimous approval to its Reference Committee's recommendations in regard to treatment of veterans

with non-service-connected disabilities by the Veterans Administration.

It is significant that the Reference Committee's recommendations followed very closely the resolution presented on this subject by the Ohio Delegation, although eight different resolutions had gone into the hopper on the policy. The Ohio resolution was adopted at the Cincinnati O.S.M.A. meeting in April.

The A. M. A. adopted policy is as follows:

"Your Committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other Federal hospitals that new legislation be enacted limiting such care to the following two categories:

"(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and

"(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

SERVICE-CONNECTED DISABILITIES

The reference committee report adopted by the House expressed complete accord with the present program of hospital and medical care for veterans with service-connected disabilities, and also included this statement:

"It is the belief of your committee that the medical profession must concern itself, not with the numbers of 'chiselers' in Veterans Administration hospitals nor with the efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the Federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of the country. A consideration of this problem must of course be predicated upon a concern for the health of the entire population and not just a particular segment."

OVERT CRITICISM DENOUNCED

Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to Dr. Paul R. Hawley, Executive Director of the American College of Surgeons. The House adopted a committee report which recommended no action on the eleven resolutions but which reaffirmed the supremacy of the A. M. A. code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing.

"The Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession," the reference committee report said. "Any statement relating to ethical matters by other organizations within the general profession of medicine advances views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association."

Condemning generalized statements regarding the ethics of physicians, the report went on to say:

"Your reference committee believes that the harm done to the public and to the profession by the current articles which lower the confidence patients have in their doctors cannot be objectively evaluated. This highlights the fact that, when individuals or groups without official status in the American Medical Association utter or publish ill-considered statements, the result too often is that the confidence of the public in the medical profession is placed in jeopardy.

"The reference committee believes that the members of the House of Delegates have demonstrated their devotion over the years to the principles of American democracy. This devotion includes the right of free speech. With this, the Committee agrees unqualifiedly.

"Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these

Dr. McCormick Gets Honorary Degree

Dr. Edward J. McCormick, incoming President of the American Medical Association, flew from New York to Cincinnati and back during the A. M. A. meeting to deliver the commencement address at Xavier University and to receive the honorary Doctor of Laws degree from that institution.

pitfalls without additional advice from this committee."

The report also urged that the American Medical Association continue to inform its members and the public of its stand on matters pertaining to abuses and evils in the practice of medicine.

RELATIONS WITH OSTEOPATHS

Most controversial issue brought before the House at the New York meeting proved to be the question of immediate or deferred action on the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The House, after two hours of debate, adopted the majority report of the Reference Committee on Miscellaneous Business, thereby postponing action until the June, 1954, meeting and allowing further study by the delegates and the state associations.

The recommendations of the Committee for the Study of Relations Between Osteopathy and Medicine, action on which was postponed for one year, were as follows:

"1. That the House of Delegates declare that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'cultist' healing.

"2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in the undergraduate and postgraduate education of doctors of osteopathy.

"3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

"4. That the Committee for the Study of Relations Between Osteopathy and Medicine or a similar committee be established as a continuing body."

FINAL ACTION POSTPONED

A minority report of the reference committee urged approval and adoption of those recommendations at the New York meeting. The majority report, which ultimately won out, included the following recommendations by the Board of Trustees:

"Because of the length of the report and the controversial nature of the subject, the Board feels that the House should have adequate time for its study and that the state associations should have opportunity to express their opinions.

"Therefore, it is recommended that the Committee be continued but that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?"

INTERNSHIPS

Five resolutions came before the House with regard to the Essentials of an Approved Internship, which were adopted at the December, 1952, meeting. The Reference Committee on Medical Education and Hospitals of which Dr. Wright of Ohio was chairman, recommended a substitute resolution which was adopted by the House after considerable discussion.

The action abolishes the rule whereby approval may be withdrawn from an internship program which for two consecutive years fails to obtain at least two-thirds of its slated complement of interns. The resolution also calls for further study of the Essentials by a committee appointed by the Speaker of the House, at least half of whom are doctors in private practice not connected with medical schools or affiliated hospitals.

Among the many other actions taken, the House reaffirmed its endorsement of the principles embodied in Senate Joint Resolution No. 1 (sponsored by Ohio's Senator John Bricker and other senators) concerning international treaties or agreements which interfere with domestic laws or rights. It approved a resolution deploring a derogatory article about the American Medical Association which appeared recently in the *Home*

Mr. Nelson Is Doubly Honored At Executive Conference

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, was twice honored at the conference of the Medical Society Executives Association in New York on June 1. He was presented a 25-Year service certification by the national organization for that many years of continuous service in medical organization work—all with the O. S. M. A. In addition, he was awarded a plaque as a "testimonial in recognition and appreciation of his services rendered" as chairman of the Medical Society Executives Association during the years 1948-1949.

Life Magazine. The latter resolution was referred to the Board of Trustees for action.

On the opening day session of the House, it was addressed by Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare.

Mrs. Hobby told the delegates that the present administration in Washington is looking with confidence to the nation's physicians for leadership in meeting the challenge of modern medical care problems. She said the special assistant on medical affairs which she would appoint would be a doctor of medicine.

The 1953 distinguished Service Award was voted to Dr. Alfred Blalock of Baltimore for his outstanding work in vascular surgery and his part in the development of the so-called "blue baby" operation.

Dr. Walter B. Martin, Norfolk, Va., was named president-elect. Dr. Carl H. Gellenthien of Valmora, New Mexico, was elected vice-president. Dr. Martin has been a member of the Board of Trustees.

"Re-elected to office were: Dr. George F. Lull, Chicago, secretary and general manager; Dr. J. J. Moore, Chicago, treasurer; Dr. James R. Reuling, Bayside, New York, speaker of the House of Delegates; Dr. E. Vincent Askey, Los Angeles, vice speaker of the House; Dr. Edwin S. Hamilton, Kankakee, Illinois; and Dr. Gunnar Gundersen, LaCrosse, Wisconsin, as member of the Board of Trustees. The House elected Dr. Julian P. Price of Florence, South Carolina, to fill Dr. Martin's unexpired term on the Board of Trustees.

McCORMICK'S NINE-POINT PROGRAM

Dr. McCormick outlined a nine-point program for further improvement in the nation's medical care, in his talk before the House of Delegates.

In offering his suggestions, he expressed the hope that "their further development will solve many of medicine's problems and eliminate much of the criticism to which we are subjected."

Excerpts from the proposals he made to the House of Delegates follow:

"First: The distribution of doctors is a problem. Much has been done by medical organizations to solve it. Placement services are now in existence in 37 states. Of these, 32 are operated by medical societies. It is important to the future of medicine that every community have access to a physician. Medicine must actively aid those communities which are trying to attract doctors.

"Second: Over 600 of our county medical societies now have 24-hour emergency call services. I urge all others to support such a system.

"Third: Every medical society must have a strong and fearless mediation committee to hear patients' complaints. These must not be whitewash committees. They must be true to the purpose of their founding by reprimanding and disciplining physicians found guilty of exploiting their patients. Only in this way can public confidence in medicine be maintained.

"Fourth: Physician and hospital relationships must be clarified and steps taken toward mutual cooperation. I advise the formation of physician-hospital committees by state and county medical societies to work toward better relations in local communities. This has already been done with some success in some states.

"Fifth: Every county society should become an active unit in the nationwide effort to develop and expand voluntary health insurance. We must find ways of providing protection against catastrophic illness and coverage of older age groups.

"Sixth: Too many physicians have been isolationists within their communities. Local societies should encourage each individual member to participate in some civic undertaking. We physicians should be rendering health leadership in all service clubs, fraternal organizations, parent-teachers groups, church associations and unions.

"Seventh: Every doctor must be brought to realize that good public relations begins in his or her office—that the way in which they treat patients reflects for good or ill on the entire profession. Medical societies are frequently hampered in their efforts to build public understanding by the doctor who overcharges, the doctor who rudely refuses to answer a night call no matter how urgent, or the doctor who keeps patients waiting for hours in his reception room without any explanation.

"Eighth: There are some newspaper and radio people who honestly believe some of the untruthful charges which have been made against medicine. All county and state societies should make continued efforts to develop a close association with writers for press, radio and television.

"Ninth: There is a need for unity within the profession. I have noticed a distressing regression toward petty internal wrangling, charges and countercharges, and divisive activities by various groups within the profession."

Dr. McCormick explained that "constructive criticism has a universally recognized place within any democratic group" but once that group has taken a majority action on a matter, the dissenters should be willing to accept the will of the majority.

Those taking part in the scientific deliberations were:

SECTION ON ANESTHESIOLOGY

Dr. Roland J. Whitacre, Cleveland, served as chairman of the Section and presented a talk on "The Anesthesiologist's Responsibility to the Patient."

Dr. Donald E. Hale, Cleveland, discussed a

paper on "Cerebral Edema and Its Relationship to Barbituric Acid Poisoning."

Dr. B. B. Sankey, Cleveland, discussed a talk on "Postoperative Nausea and Vomiting."

Dr. Lloyd E. Larrick, Cincinnati, discussed a paper on "Placental Transmission of D-Tubocurarine Chloride from Mother to Fetus."

Drs. Hamilton S. Davis and Henry E. Kretchmer, Cleveland, spoke on "The Advantages and Complications of Tracheotomy."

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Dr. Dan J. Kindel, Cincinnati, discussed a paper on "Cathode Rays in the Treatment of Malignant Lymphomas of the Skin."

Dr. Harold N. Cole, Jr., Cleveland, spoke on "Atabrine in the Treatment of Lupus Erythematosus."

Dr. James R. Driver, Cleveland, discussed a paper on "Carcinoma of the Forehead and Scalp."

SECTION ON DISEASES OF THE CHEST

Dr. Joseph C. Placak, Sr., Cleveland, was chairman of the Section and gave the chairman's address.

Dr. Irvine H. Page, Cleveland, took part in a panel discussion on "Diagnosis and Treatment of Hypertension."

SECTION ON EXPERIMENTAL MEDICINE AND THERAPEUTICS

Dr. Irvine H. Page, Cleveland, was vice-chairman of the Section.

Dr. A. C. Corcoran, Cleveland, spoke on "Recent Advances in the Treatment of Acute and Chronic Renal Insufficiency."

SECTION ON GASTROENTEROLOGY AND PROCTOLOGY

Dr. Rupert B. Turnbull, Jr., Cleveland, discussed a paper on "The Surgical Management of Ulcerative Colitis."

Dr. Paul J. Fuzy, Youngstown, discussed a paper on "Recurrent Anal Fissure: A Concept of Pathogenesis and Treatment."

Drs. Frank J. Rack and Kenneth W. Clement, Cleveland, presented a paper on "Cecostomy and Colostomy in Acute Colon Obstructions: Experiences in Ninety-Nine Cases."

SECTION ON GENERAL PRACTICE

Dr. Marion A. Blankenhorn, Cincinnati, participated in a panel discussion and symposium on "Management and Mismanagement of the Failing Heart."

SECTION ON INTERNAL MEDICINE

Dr. A. Carlton Ernstene, Cleveland, opened discussion on a paper on "Coronary Dilators and Angina: A Reappraisal." He was elected secretary of the section for the coming year.

Dr. Irvine H. Page, Cleveland, discussed a presentation of the subject, "The Clinical Use of 1-Hydrazinophthalazine and Hexamethonium in the Treatment of Hypertension."

SECTION ON LARYNGOLOGY, OTOLOGY AND RHINOLOGY

Dr. Fred W. Dixon, Cleveland, spoke on the subject, "Management of Chronic Ethmoid and Sphenoid Sinusitis."

SECTION ON NERVOUS AND MENTAL DISEASES

Dr. Louis J. Karnosh, Cleveland, served on the executive committee of this Section.

Drs. James R. Gay and Kenneth H. Abbott, Columbus, presented a paper on "Common Whiplash Injuries of the Neck."

Dr. Frank H. Mayfield, Cincinnati, spoke on "The Role of Cervical Roots in the Production of Pain in the Head and Face."

Drs. Harry M. Salzer and Max L. Lurie, Cincinnati, presented the subject, "Anxiety and Depressive States Treated with Isonicotinyl Hydrazide."

OPHTHALMOLOGY

Dr. Lorand V. Johnson, Cleveland, is secretary of the Association for Research in Ophthalmology, which held a joint meeting with the Section on Ophthalmology.

SECTION ON ORTHOPEDIC SURGERY

Dr. Nicholas J. Giannestra, Cincinnati, opened discussion on a talk on "Flake Fracture of the Astragalus."

SECTION ON PATHOLOGY AND PHYSIOLOGY

Drs. John B. Hazard and Rex Kenyon, Cleveland, presented the subject, "Atypical Adenoma of the Thyroid."

SECTION ON PEDIATRICS

Dr. Albert B. Sabin, Cincinnati, spoke on "Present Status and Future Possibilities of Vaccine for the Control of Poliomyelitis." (This was before a combined meeting with Section on Preventive and Industrial Medicine and Public Health and Section on Physical Medicine and Rehabilitation.)

Dr. Frederick N. Silverman, Cincinnati, opened discussion on the subject, "Cholecystography During the First Month of Life." (This was before a joint meeting with Section on Radiology.)

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

Dr. Walter M. Solomon, Cleveland, is vice-chairman of the Section, and Dr. Walter J. Zeiter, also of Cleveland, its secretary.

Dr. Robert M. Stecher, Cleveland, took part in a panel on arthritis, giving the "Classification of Arthritis."

SECTION ON PREVENTIVE AND INDUSTRIAL MEDICINE AND PUBLIC HEALTH

Three Ohio physicians have key positions on this Section. Dr. Frank Princi, Cincinnati, is

secretary; Dr. Rutherford T. Johnstone, Cincinnati, is delegate; and Dr. Paul A. Davis, Akron, is representative to Scientific Exhibit.

Dr. John J. Phair, Cincinnati, spoke on "Biological Warfare in Civil Defense."

Dr. James P. Hughes, Cincinnati, spoke on "Industrial Medical Service by Private Practitioners."

Dr. E. M. Kline, Cleveland, presented a paper on "The Cardiac in Industry."

Dr. Raymond R. Suskind, Cincinnati, read a paper on "An Industrial and Laboratory Evaluation of a Silicone Protective Cream."

SECTION ON RADIOLOGY

Dr. Hymer L. Friedell, Cleveland, opened discussion on the subject, "Therapeutic Value of Radioisotopes in a General Hospital."

SECTION ON SURGERY, GENERAL AND ABDOMINAL

Dr. Claude S. Beck, Cleveland, opened discussion on "The Treatment of Cardiac Arrest and Ventricular Fibrillation."

Drs. Robert M. Zollinger and E. H. Ellison, Columbus, spoke on "Nutrition Following Gastric Operations for Peptic Ulcer."

SECTION ON UROLOGY

Dr. Charles C. Higgins, Cleveland, spoke on the subject, "The Clinical Significance of Hematuria."

THE SCIENTIFIC EXHIBIT

The following Ohio physicians presented scientific exhibits or took part in the exhibits:

Dr. Ralph G. Carothers, Cincinnati, was a member of the committee which presented a Special Exhibit on Fractures. Taking part in demonstrations were: Drs. F. Paul Duffy, Nicholas J. Giannestras and Theodore H. Vinke, all of Cincinnati.

Dr. E. A. Marshall, Huron Road Hospital, East Cleveland, "An Experiment in Treatment of Peptic Ulcer with Unrestricted Diet."

Dr. Zale A. Yanof, Toledo, "Value of Intravenous Sodium Amytal in Psychosomatic Disorders: Neglect of Its Use in General Practice."

Drs. Victor Strauss, David L. Simon, Arnold Iglauer and Johnson McGuire, Cincinnati General Hospital, "Parenteral Use of Digitoxin."

Dr. William L. Proudfit, Cleveland Clinic, and Dr. J. F. Dobosy, Avon Lake, "Tape Recording Electrocardiography."

Dr. Donald J. Lyle, Cincinnati, is a member of the exhibit committee of the Section on Ophthalmology.

Drs. Fay A. LeFevre, A. W. Humphries and V. G. DeWolfe, Cleveland Clinic, "Diagnosis of Aorta-Iliac Artery Occlusion."

Drs. U. K. Henschke, W. M. McLellon, B. H. Colmery, Jr., and William G. Myers, Ohio State University College of Medicine, "Radioactive Gold Gamma-Ray Sources in Radiation Therapy."

Drs. Charles H. Brown, Stanley O. Hoerr and R. G. Perryman, Cleveland Clinic, "Carcinoma of the Stomach—Changes in Surgery from 1940 to 1951.

Drs. Stanley O. Hoerr and Rupert B. Turnbull, Jr., Cleveland Clinic, "Trans-Abdominal Gastroscopy and Coloscopy."

Drs. James W. Papez and B. Pearl Papez, Columbus State Hospital, Columbus, "Pituitary Gland in Mental Illness as Seen Under Phase Microscope."

New Members of O.S.M.A.

Following are the names of new members of the Ohio State Medical Association since May 27, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BELMONT COUNTY
Paradise, Jack L., Bellaire

CLARK COUNTY
Swanton, William, Springfield

CUYAHOGA COUNTY
Dunne, Edward F., Cleveland
Friesen, Arnold R., Cleveland
Hackel, Donald B., Cleveland
Hewlett, James S., Cleveland
Hoch, Carl W., Cleveland
Michels, Albert J., Jr., Cleveland
Pasterak, George E., Cleveland
Pautienis, Kazimieras, Cleveland
Rammelkamp, Chalres H., Jr., Cleveland
Reulbach, Franklin P., Cleveland
Sukarevicius, John, Cleveland
Van Erp, Ymkje M., Wickliff
Whitsett, Charles C., Cleveland

DELAWARE COUNTY
Blydenburgh, George D., Delaware

FRANKLIN COUNTY
Carter, Neal D., Columbus
Newkirk, Ernest M., Columbus
Todd, William E., Columbus
Wall, Robert L., Columbus

GALLIA COUNTY
Bean, Lewis A., Cleveland

GREENE COUNTY
Najm, Tamin, Military Service

HAMILTON COUNTY
Carson, Robert P., Cincinnati
Casper, Joseph M., Cincinnati
Conrad, Paul J., Cincinnati
Edlin, Philip, Cincinnati
Kiely, Charles E., Jr., Cincinnati
Nitchals, Jeanne E., Cincinnati
Wilson, Jesse Rodman, Cincinnati

HANCOCK COUNTY
McCandliss, Robert, Findlay
Miller, Robert E., Findlay

LUCAS COUNTY
Crockett, Roy E., Trilby
Tremblay, Albert J., Trilby

MAHONING COUNTY
Altman, George L., Youngstown
Hardin, Wayne B., Youngstown
Ruth, Paul E., Youngstown

MONTGOMERY COUNTY
Allen, A. G., Dayton
Fleischl, Herbert, Dayton
Kuhr, Bernard M., Dayton

SUMMIT COUNTY
Held, Burt, Akron
Rosenthal, Harry L., Akron

STARK COUNTY
Mueller, Louis E., Canton

Granville—Dr. Lawrence H. Miller has been named professor of health education and director of student health services at Denison University effective in the fall. He will continue his private practice. He succeeds Dr. Russel H. Williams who held the position from 1926 until last September.

Conferences for Medical Assistants . . .

Two of Ohio's Metropolitan Societies Put on Program Especially Designed To Help Those in Doctors' Offices Meet Growing Demands

TWO of Ohio's metropolitan county medical societies recently held successful public relations conferences for medical assistants and both reported large turnouts and encouraging response to the programs.

COLUMBUS MEETING

The Columbus Academy of Medicine reported an attendance of 200 medical assistants at its first annual "Public Relations Institute," held May 14 in the Seneca Hotel, Columbus.

At the Columbus meeting, dinner was served after which a program was held under chairmanship of Dr. Robert C. Kirk, president of the Columbus Academy of Medicine.

The subject, "Medical Public Relations," was discussed by Walter Seifert, of Byer & Bowman, Columbus advertising firm.

"Your Doctor," a sound film from the American Medical Association, was another feature of the program.

Dr. Thomas E. Rardin spoke on "What Every Doctor Hopes for from His Medical Assistants."

The program was concluded with a panel discussion by the following persons answering questions from the audience: Drs. Judson D. Wilson, Mel A. Davis, Robert C. Kirk, Thomas E. Rardin and Harrison S. Evans and Mr. Stanley R. Mauck, executive secretary of the Academy.

CLEVELAND MEETING

The Academy of Medicine of Cleveland reported a turnout of 325 persons for its Public Relations Clinic for Medical Personnel held on April 8 in the Hotel Cleveland.

The *Cleveland Academy Bulletin* reported that since many of the medical assistants who attended work for several doctors that the attendance represented a major cross section. A number of physicians also were present.

Many thoughtful questions were asked of the speakers on such subjects as scheduling, discussing fees, credit, telephone procedures and insurance.

A questionnaire was handed out at the meeting. Results of the questionnaire are being compiled for presentation in the *Bulletin.*



Here is part of the group of approximately 200 medical assistants who responded when Columbus Academy put on special program for them.



1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*



2



3

TYPES OF VERTIGO:

Their symptomatic relief with Dramamine®

The disagreeable sensations of dizziness which physicians are frequently required to explain to patients have been described by Simonton[1] as varying from a slight sensation of confusion to severe vertigo.

While dizziness or giddiness is classified as a sensation of unsteadiness with a feeling of movement within the head, in vertigo the environment seems to spin (objective vertigo) or the body to revolve in space (subjective vertigo). Labyrinthine disturbances are likely to cause a sensation of rotation. Among the more common causes of dizziness or vertigo, this author lists: Damage to the vestibular nuclei or tracts in the central nervous system, involvement of the vestibular end organs by disease of the ear, Ménière's disease, toxicity of drugs, ocular vertigo from sudden diplopia, visual field defects, looking down from heights and motion sickness due to hyperactive labyrinthine reaction from riding in vehicles.

Dramamine (brand of dimenhydrinate) has proved effective in treating many of these disturbances. The indications for which Dramamine is now Council accepted include: Motion sickness, the nausea and vomiting associated with pregnancy, certain drugs, electroshock therapy and narcotization; vestibular dysfunction associated with streptomycin therapy; the vertigo of Ménière's syndrome, hypertensive disease and that following fenestration procedures, labyrinthitis and radiation sickness.

1. Simonton, K. M.: The Symptom of Dizziness, Arizona Med. *6*:28 (Sept.) 1949.

SEARLE *Research in the Service of Medicine*

Ohio Legislature . . .

General Assembly Still Going Strong; Adjournment Time Uncertain; Two Bills Opposed by O.S.M.A. Killed Through Good Work "Back Home"

AS this issue went to press, the Ohio Legislature was still going strong but hoping to adjourn sometime between July 1 and July 15. To date, no legislation detrimental to the health and medical programs of the state had been enacted. At the same time, several constructive measures have been passed. A complete review of the legislative session will be published in *The Journal* following adjournment.

Two bills which the medical professional felt would be against the public's interest and actively opposed by the Ohio State Medical Association were defeated late in May.

TWO BILLS BEATEN

One of these was **House Bill 232** which would have created a separate examining and licensing board for chiropractors; extended the rights of these limited practitioners; and, through a "grandfather clause," given licenses to those now practicing without a license.

The other measure was **Senate Bill 227** which would have created a new state department of occupational and professional licensing. It would in effect have abolished the present boards, including the medical board, and given the governor authority to appoint new boards which would have been advisory in character, under the director of the proposed new department.

CHIROPRACTIC PROPOSAL

The chiropractic bill was definitely buried when the House by a vote of 62 to 55 refused to approve a motion to reconsider the vote by which the bill had been laid on the table when it first came before the House for action. It had been tabled by a vote of 57 to 55. It takes 69 affirmative votes to pass a bill in the House.

LED FIGHT AGAINST BILL

The floor fight against the bill was led by the following representatives: Harold Oyster, Marietta; Frank McClure, Loudonville; Mrs. Mundy, Toledo; Robert Johnson, Medina; and Leslie Burge, Lorain. Cedric Stanley, Lebanon, and Grover Kinley, Ironton, were prepared to speak against the bill but did not get a chance to do so as debate was cut off by a motion.

THESE SPOKE FOR IT

Those who supported the bill on the floor were: George Hook, Georgetown, and Joseph Avellone, Cleveland, authors of the bill; Howard Williams, Girard; Harry Bellis, Van Wert; and Frederick Bowers, Dayton.

VOTED AGAINST CHIROPRACTIC BILL

Following are the names of representatives who voted against the motion to reconsider H. B. 232 and therefore, against the bill, and who should be congratulated by their physician constituents:

Ankeney (Greene)
Applegate (Jefferson)
Barrett (Mahoning)
Barton (Cuyahoga)
Bauer (Stark)
Beckwith (Morgan)
Burton (Cuyahoga)
Caryl (Union)
Cooley (Vinton)
Corrigan (Cuyahoga)
Devine (Franklin)
Gardner (Williams)
Gernheuser (Lucas)
Gindlesberger (Holmes)
Groneman (Hamilton)
Hardy (Sandusky)
Hayden (Clermont)
Heft (Monroe)
Henderson (Guernsey)
Hickson (Fairfield)
Hiner (Stark)
Hooper (Adams)
Johnson (Medina)
Katterheinrich (Auglaize)
Kinley (Lawrence)
Lancione (Belmont)
Lewis (Perry)
Lingler (Butler)
Longenecker (Wood)
Longfellow (Darke)
McClure (Ashland)
McMahon (Cuyahoga)
Meinhart (Meigs)
Mikeseil (Preble)
Miller (Cuyahoga)
Milleson (Harrison)
Milner (Highland)
Mitch (Clark)
Mundy (Lucas)
Owens (Jackson)
Oyster (Washington)
Perrill (Fayette)
Reckman (Hamilton)
Renner (Hamilton)
Reynolds (Lucas)
Rittenour (Ross)
Roberts (Franklin)
Robinson (Marion)
Shaylor (Ashtabula)
Short (Miami)
Stanley (Warren)
Stotzer (Fulton)
Sweet (Lake)
Taber (Gallia)
Taylor (Lucas)
Wallace (Pickaway)
Weisenborn (Montgomery)
Wheeler (Morrow)
Woods (Scioto)
Woods (Cuyahoga)
Zellar (Muskingum)
Zuber (Franklin)

WANTED BILL RECONSIDERED

The names of the members who voted for the motion to reconsider the tabling of H. B.232 are as follows:

Avellone (Cuyahoga)
Beery (Shelby)
Bellis (Van Wert)
Bowers (Montgomery)
Bright (Hocking)
Burge (Lorain)
Calabrese (Cuyahoga)
Campbell (Athens)
Cassel (Wyandot)
Chapman (Geauga)
Chester (Franklin)
Corkwell (Putnam)
Crosser (Cuyahoga)
Damas (Lucas)
Deming (Licking)
Drake (Crawford)
Dunn (Tuscarawas)
Evans (Portage)
Harter (Summit)
Hinkle (Mercer)
Hook (Brown)
James (Noble)
Kile (Madison)
Kirkpatrick (Knox)
Glandorf (Hamilton)
Gorman (Cuyahoga)
Griffin (Allen)
Kilpatrick (Trumbull)
Lehmann (Stark)
Longsworth (Carroll)
Lynch (Mahoning)
Manahan (Defiance)
McCaffery (Cuyahoga)
McGettrick (Cuyahoga)
Miller (Paulding)
O'Hara (Columbiana)
O'Neil (Summit)
Patten (Montgomery)
Putka (Cuyahoga)
Reider (Ottawa)
Sawicki (Cuyahoga)
Sexton (Butler)
Simmonds (Hamilton)
Sours (Summit)
Sullivan (Cuyahoga)
Sweeney (Cuyahoga)
Sweeney (Summit)
Tablack (Mahoning)
Thomas (Summit)
Thurston (Henry)
Wade (Lorain)
Weaver (Huron)
Williams (Trumbull)
Yoder (Montgomery)
Young (Erie)

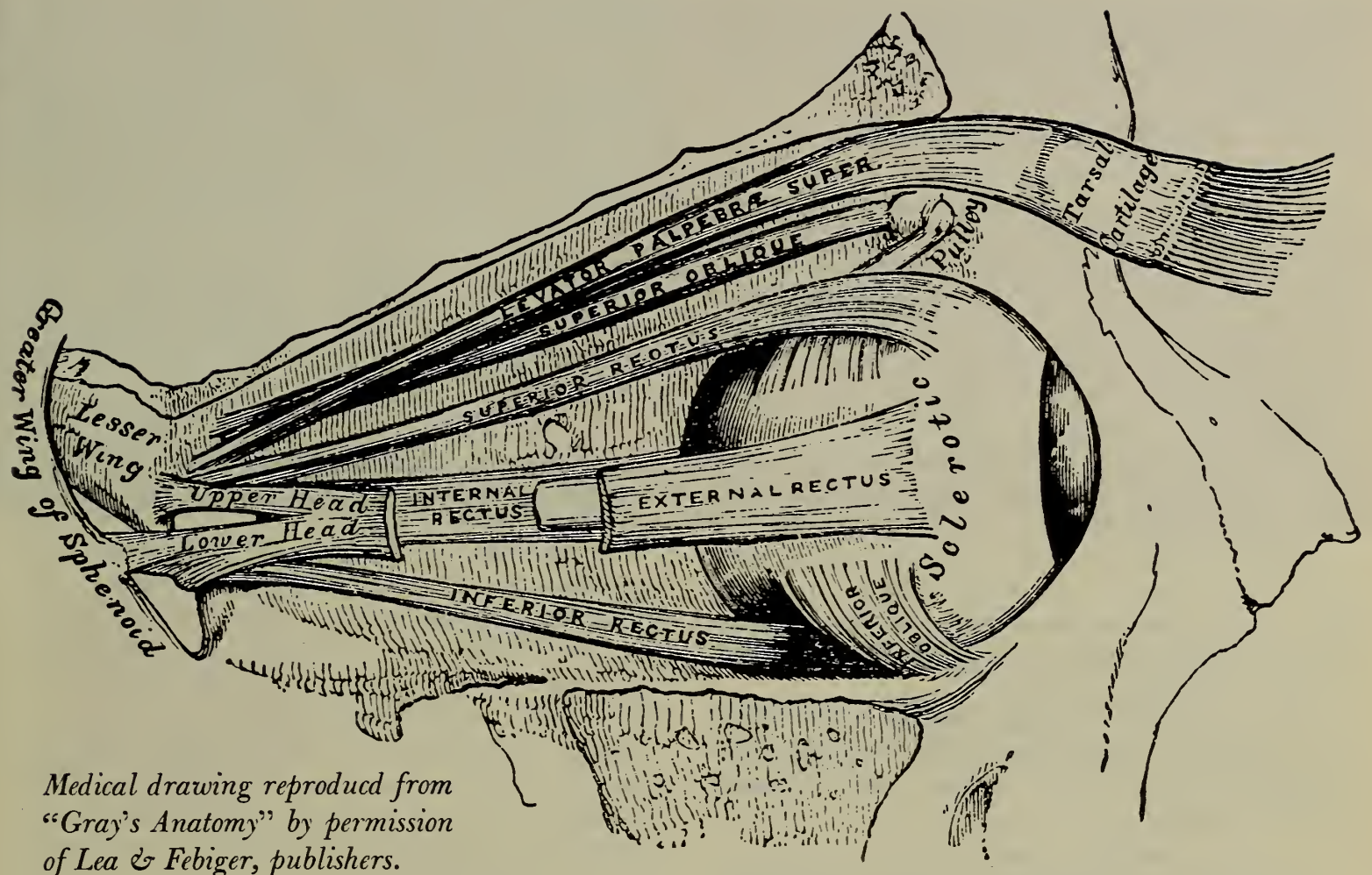
Those who were absent or did not vote on the motion to reconsider were:

Bennett (Hancock)
Berry (Coshocton)
Bettman (Hamilton)
Clark (Hamilton)
Cloud (Logan)
Crowl (Montgomery)
Edmonston (Franklin)
Fink (Cuyahoga)
Fisher (Wayne)
French (Delaware)
Lady (Hardin)
Leist (Pike)
McClure (Hamilton)
Nicely (Clinton)
Robinson (Richland)
Schneider (Hamilton)
Troop (Franklin)
Turner (Seneca)
Saxbe (Speaker does not vote except in case of tie)

EXPLANATION OF VOTING

In all probability there were some among the 55 Legislators who voted for the motion to reconsider who would have voted against H. B. 232

When a patient just can't <u>see</u> giving up coffee . . .



Medical drawing reproduced from "Gray's Anatomy" by permission of Lea & Febiger, publishers.

Tell him about grand-tasting Sanka Coffee. It's 97% caffein-free . . . can't cause sleeplessness or get on the nerves.

SANKA

The perfect coffee for the patient affected by caffein.



Products of General Foods

had it come up on the House floor to be voted on on its merits. Some members of the House felt there should have been an outright vote on the bill itself. For that reason they wanted it taken off the table and subjected to a roll call vote on its passage. Also, some who were absent would have voted against the motion and against the bill had they been present. Also, we feel sure that some who were present and did not vote on the motion to reconsider would not have voted FOR the bill had a vote been taken on the bill itself.

"RIPPER BILL" ALSO LICKED

Senate Bill 227, which proposed the creation of a new cabinet department for the licensing of occupations and professions, was given only one hearing before the Senate Judiciary Committee. On the night of May 20, the committee in a surprise move, inserted a few minor amendments and reported out the bill, recommending it for passage. It took its place on the general calendar of the Senate on Monday, May 25. On Tuesday afternoon, the Rules Committee placed it on the "jitney" calendar of the Senate for Wednesday, May 27.

This unusual action and, to say the least, speedy maneuver, caught everyone by surprise, including most of the members of the Senate who had not even had a chance to read the bill and knew little, if anything about it.

When the bill was brought up for a vote, Senator Sheppard, Akron, author of the bill, spoke for the bill, severely criticizing the licensing boards, generally.

SPOKE AGAINST BILL

Opposition to the measure was led by Senator Bartunek, Cleveland, minority (Dem) floor leader; Senator Oakley Collins, Ironton; Senator Theodore Gray, Piqua; and Senator Wilbur Shull, Columbus.

At one time during the debate Collins moved that the bill be recommitted to the Judiciary Committee but the motion failed on a tie vote, 13 to 13.

When the roll was called on passage of the bill, the vote was 10 votes for the bill and 17 against. Seventeen votes are required to pass a bill in the Senate.

HOW THEY VOTED

These are the senators who voted against S. B. 227 and should be thanked:

Baker (Montgomery-co) R
Bartunek (Cuyahoga-co) D
Bernard (Mahoning-co) D
Blake (Belmont-co) D
Carney (Mahoning-co) D
Collins (Lawrence-co) R
Corrigan (Cuyahoga-co) D
Dell (Butler-co) D
Ferguson (Guernsey-co) R
Fess (Greene-co) R
Mrs. Gorman (Cuyahoga) D
Gray (Miami-co) R
Hildebrand (Lucas-co) R
Hoffman (Hamilton-co) R
Mosher (Lorain-co) R
Shull (Franklin-co) R
Svoboda (Cuyahoga-co) D

Those who voted in favor of S. B. 227 were:

Danner (Summit-co) R
Davis (Cuyahoga-co) R
Deddens (Hamilton-co) R
Latta (Hancock-co) R
Mechem (Athens-co) R
Moorehead (Muskingum) R
Pepple (Allen-co) R
Pollock (Stark-co) R
Sheppard (Summit-co) R
Tyrrell (Preble-co) R

Those who were absent or did not vote on S. B. 227 were:

Celebrezze (Cuyahoga-co) D
Humphrey (Ashtabula-co) R
King (Lucas-co) D
Rolf (Hamilton-co) R
Shaw (Franklin-co) R
Simpson (Hardin-co) R

(Senator Rolf was presiding over the Senate in place of the Lieutenant-Governor at the time the vote was taken. It is customary for the presiding chairman not to vote on bills.)

GOOD WORK IN COUNTIES

The tough battles on these two bills were won because of the excellent job done "back home" in most counties by legislative chairmen and other physicians. When county medical society officials and members of the State Legislative Committee were alerted from Columbus, they got busy immediately and the effect of their work was evidenced by the outcome of the ballotting on these bad proposals.

Cincinnati Doctors and Attorneys Work Toward Cooperative Plan

The Academy of Medicine of Cincinnati and the Cincinnati Bar Association are making encouraging progress in their efforts to formulate practical "Standards of Practices" through which local doctors and lawyers can work in harmony when their professional interests cross.

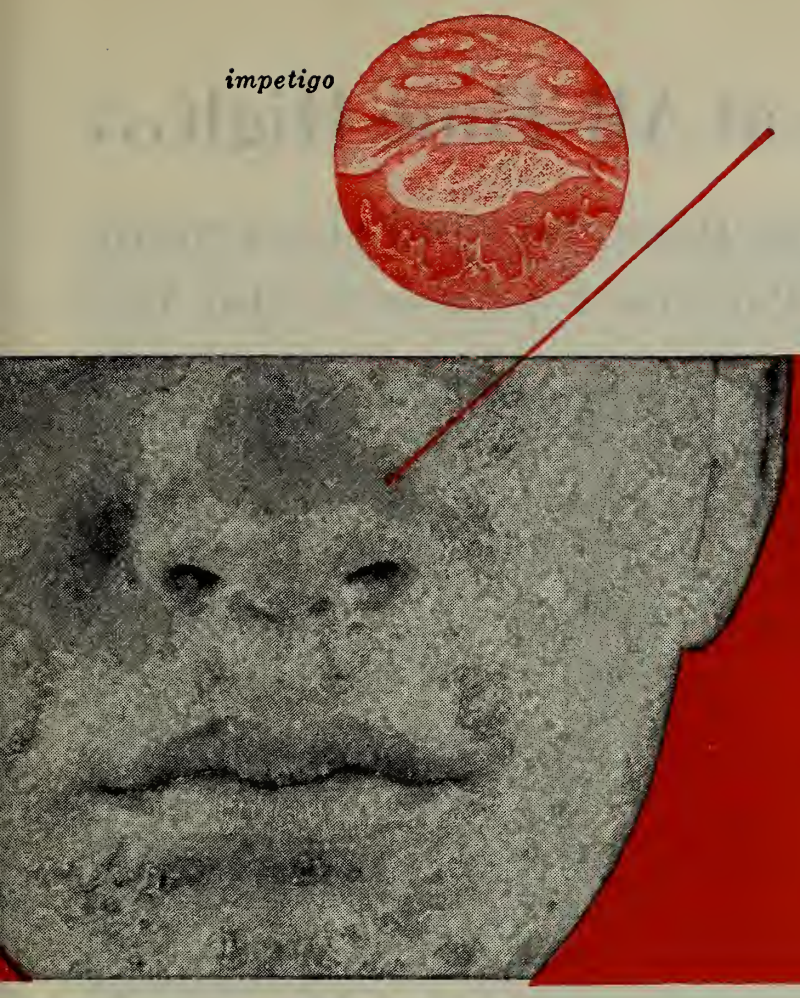
Latest contribution to this progress was a joint meeting between the two organizations at which a panel discussed tentative standards of practices previously formulated by committees of the two groups.

Taking part on this panel were Dr. Daniel E. Earley, president of the Academy of Medicine; Judge Chester R. Shook, president of the Bar Association; Drs. F. H. Mayfield, D. W. Heusinkveld, and Attornies R. F. Dreidame and C. R. Beirne. Judge Otis R. Hess, of the Common Pleas Court, was moderator.

Among subjects discussed by the panel were the following: The question of a fee for reports of records already available; the question of fees for additional examinations; reports requested by someone other than the plaintiff; limitations of the information needed by the attorney; conferences between doctor and attorney and due notice of subpoenaes; question of a consultation fee; scheduling of court hearings.

Additional conferences are to be held before a final draft of "Standards of Practices" are agreed upon.

The Cincinnati Academy had reprints made of the article, "Medicine vs. Law," by Dr. Sidney Shindell which appeared in the March 28 issue of *The Journal of the American Medical Association*, which the Bar Association distributed to its members.



skin infections and antibiotics

Since cutaneous bacterial infections "probably account for more disability than any other group of skin diseases,"[1] the availability of broad-spectrum Terramycin has been particularly helpful in controlling these common disorders. This pure, well-tolerated antibiotic is markedly effective against the wide range of organisms often implicated as primary or secondary pathogens in skin disease. Successful clinical experience[2,3,4] in the treatment of impetigo, acne, pyodermas, erythema multiforme and other cutaneous infections recommends the selection of Terramycin as an agent of choice in common diseases of the skin. Terramycin is supplied in convenient oral and intravenous dosage forms.

1. *Bednar, G. A.: South. M. J.* 46:298 *(March) 1953.*
2. *Wright, C. S. et al.: A. M. A. Arch. Dermat. & Syph.* 67:125 *(Feb.) 1953.*
3. *Robinson, H. M. et al.: South. M. J. (in press).*
4. *Andrews, G. C. et al.: J. A. M. A.* 146:1107 *(July 21) 1951.*

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Number of Physicians at All-Time High...

A.M.A.'s Report of State Licensing Boards for 1952 Shows Nearly Three Thousand Were Added To Physician Population in That Year

THERE were more physicians in the United States at the close of 1952—214,667—than at any other time in its history, it was disclosed in the 51st annual medical licensure report of the Council on Medical Education and Hospitals of the American Medical Association.

During 1952, 6,816 persons were licensed to practice medicine in the continental United States for the first time. During the same period, 3,829 deaths of physicians were reported to the A. M. A., giving a net increase of 2,987 in the physician population of the nation. In 1951, an increase of 2,640 was reported.

Ohio licensed 418 newly graduated physicians who represent additions to the medical profession in 1952—365 by examination and 53 by reciprocity and endorsement. Actually the State Medical Board licensed 686 persons—393 by examination and 293 on the basis of reciprocity and endorsement, but these latter figures represent duplications, many of the licentiates being licensed also in other states.

In the 18-year-period from 1935 to 1952, there have been 110,700 additions to the medical profession throughout the country. This is the result of the increase in the production of physicians under accelerated programs in medical schools, expanded facilities and the licensure of foreign-trained physicians, the report stated.

NATURE OF WORK

Of the total number of physicians in the United States at the close of 1952, 151,363 were engaged in private practice, 6,677 were in full-time research and teaching, 28,366 were interns, residents, and physicians engaged in hospital administration, 8,166 were retired or not in practice, and 20,095 were in the government services.

Medical licensure in this country is a "state right" and is entirely under the jurisdiction of the governments of the individual states, it was emphasized by Dr. Donald G. Anderson, Chicago, secretary of the council. The report appears in the May 30 issue of the *Journal of the American Medical Association.*

A total of 13,228 licenses to practice medicine were issued in the continental United States, its possessions and its territories during 1952; this included 6,885 issued to persons for the first time. The remainder were issued to physicians who moved their practice from one state to another. These licenses were issued upon examination or certification of credentials.

The greatest number of licenses, 1,581, were issued in California. New York licensed 1,292 physicians, and more than 500 licenses were issued in Florida, Illinois, Ohio, Pennsylvania, and Texas each. Delaware, Maine, Montana, Nevada, North Dakota, South Dakota, Vermont, and Wyoming each issued less than 50.

MEDICAL SCHOOL GRADUATES

The high rating of the nation's 72 approved four-year medical schools was emphasized by the number of candidates who successfully passed examinations. Of the 5,434 graduates of approved medical schools in the United States, 97.3 per cent passed. Of the 128 graduates of approved schools in Canada, 93 per cent passed. In comparison, of the 1,208 graduates of foreign medical faculties, only 53.7 per cent passed; only 26.7 per cent of the 60 graduates of the now extinct unapproved medical schools in the United States passed, and 80.4 per cent of the 194 graduates of schools of osteopathy passed.

Of Ohio's three medical schools, the report shows that of 305 graduates who took the examinations (including Part 3, Examination of the National Board of Medical Examiners), 298 passed. The breakdown is as follows: University of Cincinnati College of Medicine, 108 examined, 105 passed; Western Reserve University School of Medicine, 99 examined, 98 passed; Ohio State University College of Medicine, 105 examined, 102 passed.

APPROVED FOREIGN SCHOOLS

In February, 1950, the Council on Medical Education and Hospitals of the A. M. A. and the Executive Council of the Association of American Medical Colleges first published a list of foreign medical schools whose graduates they recommended for consideration on the same basis as graduates of approved medical schools in the United States and Canada, the report pointed out. Today, there are 50 such schools in 14 countries on the list.

In 1936, the number of foreign-trained physicians seeking licensure to practice in the United States began to increase, and by 1940 over three times as many were tested as in 1936, the report stated. Beginning in 1944, the number began to decrease; in 1951 and 1952 there was a noticeable increase again. At no time did fewer than 30.7 per cent of these foreign-trained examinees fail in a given year.

Medical Float in Sesqui Parade . . .



The above float, honoring Dr. Edward Tiffin, first Governor of Ohio, is shown as it appeared in the Columbus Sesquicentennial Parade on Sunday, May 3. It was jointly sponsored by the Ohio State Medical Association, the Ohio Academy of General Practice and the Franklin County Academy of General Practice. Dr. Sydney N. Lord, Westerville, president of the Franklin County Academy of General Practice, portrayed Dr. Tiffin as the first governor. John Swank, Otterbein College divinity student, portrayed him as a minister, while Dr. Charles W. Matthews, president-elect of the Franklin County Academy of General Practice, portrayed the pioneer as an attorney. Also on the float were Dr. Robert C. Kirk, president of the Columbus Academy of Medicine, and Dr. Philip B. Hardymon, secretary-treasurer of the Columbus Academy.

A. M. A. Offers Two New Exhibits

Two new exhibits will be available for showing this fall, the A. M. A. Bureau of Exhibits reports. One exhibit—"Accidental Poisoning in Children" —is based on authentic fatal accident cases, while the other—"A Medical Service Program for Your Community"—covers various activities of medical societies and voluntary and public health agencies.

The exhibit on accidental poisonings, from the Committee on Pesticides, emphasizes points of danger in the home, yard and selected farm locations. When staffed with trained personnel, this makes an effective showing at public gatherings, state and county fairs, food and home shows.

Rapid Increase of Population Will Continue This Year

The population of the United State will pass the 160,000,000 mark before the close of 1953, Metropolitan Life Insurance Company statisticians predict.

Last year's increase was about 2,675,000, bringing the population total by year's end to more than 158,400,000. This gain, a result of the sustained high level of births, a low death rate, and a sizable immigration, establishes a new high mark, exceeding the 1951 increase by a small margin.

"It is doubtful whether a gain of equal magnitude will be experienced for many years to come, partly because of the new restrictions on immigration," the statisticians comment. "Also, some slackening in the rate of growth of our population must be expected in the near future because the young people now approaching the marriageable ages are those who were born during the depression years when the number of births was low."

The statisticians point out that since the census in the spring of 1950, the country's population has gained about 7,275,000, a figure which is not much less than the combined populations of Chicago, Los Angeles, and Detroit.

Dr. E. M. Gordon has been appointed as medical officer in charge of the Public Health Service Leprosarium at Carville, Louisiana.

Auxiliary Annual Meeting . . .

Reports Are Made of the Conference Held in Cincinnati, April 21-22 Where Attendance Was Reported at 359; List of New Officers Given

THE Woman's Auxiliary to the Ohio State Medical Association this year for the first time confined its annual convention to a two-day meeting, April 21 and 22 in Cincinnati at the Sheraton Gibson Hotel. The day preceding and the day following the regular meeting were taken up with pre-convention and post-convention meetings.

An excellent attendance was recorded with registration showing the following breakdown: Board members, 26; honorary member, 1; delegates, 54; alternates, 31; members out of Hamilton County, 132; members from Hamilton County, 115; total, 359 members.

To facilitate matters, registration, displays and meeting rooms were on one floor, while luncheons, social functions and hospitality rooms were on another floor of the same hotel. More than a hundred people made use of the hospitality room as shown by the guest register. A total of 27 guests were present at the two luncheons and pre-convention board dinner.

The convention was opened with an invocation by the Rev. John H. Lamy, D. D., pastor, First Presbyterian Church, College Hill, and by an address of welcome by Dr. Daniel E. Earley, president of the Hamilton County Medical Society.

Mrs. William H. Lippert, president of the Hamilton County Auxiliary, served as co-chairman to Mrs. Carl H. Wendel for the convention. Mrs. Paul Woodward of Cincinnati, the state president, conducted all meetings.

The second day's business, featuring panel discussions was climaxed by a luncheon honoring Mrs. Ralph Eusden, president of the National Auxiliary; Dr. E. J. McCormick, president-elect of the A. M. A.; Dr. H. M. Clodfelter, O. S. M. A. president; Mrs. N. M. Reiff, president-elect; and Mrs. Woodward, incumbent president. The new officers were installed by Mrs. Eusden. A musical program under the direction of Mrs. Charles Sherrick highlighted the luncheon. A choral group with Mrs. Daniel V. Jones as accompanist, presented an ensemble composition, including "Choral Grace" by Mrs. Margaret McClure Stitt, a local Auxiliary member.

Thomas A. Hendricks, secretary of the Council on Medical Services of the A. M. A., was the featured speaker at the Tuesday luncheon. His topic was "Homework Comes First." This talk was followed by a humorous fashion show skit by the Hamilton County Auxiliary members and the Pogue Department Store.

Tuesday afternoon and Wednesday morning were devoted to convention conferences and schools of instruction, all of which were well attended. On Tuesday evening the Cincinnati Gas and Electric Company gave a demonstration of the "Take It Easy" kitchen and showed the RKO film, "Your Doctor" in the Gas and Electric Company Auditorium.

A check for $25.00 was given to the American Medical Education Fund from the convention corsage fund. A committee of three Hamilton County members made artificial orchid corsages for guests to be used instead of real corsages and that amount was saved for the A. M. E. F.

OFFICERS

Mrs. N. M. Reiff, Washington Court House, was installed as president to succeed Mrs. Paul Woodward, Cincinnati. Mrs. Woodward continues on the Board as immediate past-president.

Other State officers are: Mrs. Paul Hancuff, Toledo, president-elect; Mrs. O. W. Jepson, Canal Winchester, vice-president; Mrs. O. Reed Jones,

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A Marked Advance in

oral estrogen therapy

1. Reich, W. J. et al. (1951), A Recent Advance in Estrogenic Therapy. I. Amer. J. Obst. & Gynec., 62:427, August. 2. Perloff, W. H. (1951), Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 3. Reich, W. J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

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Cambridge, recording secretary; Mrs. James E. Rose, Washington Court House, corresponding secretary; Mrs. Karl Ritter, Lima, treasurer.

DISTRICT DIRECTORS

The following district directors were named: First District, Mrs. Gaston Hannah, Glendale; Second, Mrs. William B. Mansur, Dayton; Third Mrs. J. M. McBride, Lima; Fourth, Mrs. M. G. Means, Toledo; Fifth, Mrs. Stanley N. P. DeVille, Rocky River; Sixth, Mrs. M. T. Knappenberger, Warren; Seventh, Mrs. Herbert Van Epps, Dover; Eighth, Mrs. Walter Devine, Zanesville; Ninth, Mrs. Harry Nenni, Ironton; Tenth, Mrs. E. J. Marsh, Broadway; Eleventh, Mrs. R. Conald Campbell, Mansfield.

The various committees for the convention were headed by Mesdames Joseph R. Nielander, William C. Schmidter, Calvin F. Warner, Herbert J. Brinker, William L. Roach, F. William Vockell, Vincent J. Seiwart, Kent E. Martin, Richard W. Vilter, Harry K. Hines, Harry F. Fry, John D. Marioni, Don N. Berning, Nicholas J. Giannestras, Ralph W. Eady, Virgil D. Hauenstein, Joseph H. Gildcamp, Richard D. Bryant, Harold G. Reineke, and J. L. Tuechter.

Mrs. Cooperrider Is Named To Head National Committee

Seventeen delegates of the Woman's Auxiliary to the Ohio State Medical Association attended the Annual Meeting of the Woman's Auxiliary to the American Medical Association in New York, Mrs. N. M. Reiff, Washington C. H., president of the State organization, reported. In addition to the official representatives, a number of Ohio ladies also attended.

Mrs. George W. Cooperrider, Columbus, chairman of the American Medical Education Foundation committee in Ohio, reported that of Ohio's 56 organized county units 48 had contributed to the Fund with a total of $2,506.00. This gave the Ohio Auxiliary third place in the Nation.

Mrs. Cooperrider was distinguished by being named chairman of the national program committee.

The delegates were privileged during their stay in New York to have luncheon in the delegates dining room of the United Nations and to observe proceedings of the U. N. Arrangements were made by Mrs. C. W. Kirkland, Bellaire.

Relics, including an injured section of vertebrae showing the path of the bullet that killed John Wilkes Booth, and copies of important documents relating to the death of Abraham Lincoln and Booth are now on permanent display at the Medical Museum of the Armed Forces Institute of Pathology in Washington.

Do You Know? . . .

Dr. John H. Skavlem, medical director of Dunham Hospital, Cincinnati, was named president-elect of the National Tuberculosis Association at its annual meeting in Los Angeles.

* * *

Dr. William A. Altemeier, Cincinnati, professor and head of the Department of Surgery, University of Cincinnati College of Medicine, left in May for a two-months tour of facilities in the Korean theater as civilian consultant on special surgical research for the U. S. Army.

* * *

The Jewish Hospital Association, Cincinnati, celebrated 103 years of continuous operation with the dedication of the new Emil Frank Pavilion on May 24. The institution now occupies 14 buildings. The new pavilion adds 140 beds, provides for expansion of the obstetrical and pediatric service and contains a large cafeteria.

* * *

The Cincinnati Surgical Society elected Dr. Ralph Good as president-elect in May. He will become president in the fall of 1954. Dr. Daniel Earley will succeed Dr. Clyde S. Roof as president this fall. Other officers elected are Dr. Carl Hochhausler, secretary and Dr. Spencer Hagen, treasurer.

* * *

Physicians who are interested in the Sixth Pan-Pacific Surgical Congress to be held in Honolulu, October 7-18, should write for information as follows: F. J. Kinkerton, M. D., director general, Pan-Pacific Surgical Association, Suite 7, Young Hotel Building, Honolulu, Hawaii.

* * *

A $10,000 unrestricted scholarship raised by the Class of '28, University of Cincinnati College of Medicine, was presented to the College at the annual University of Cincinnati Alumni Association meeting on June 4.

* * *

A compliment was paid to American medicine when Great Britain's Anthony Eden came to this country for surgery. His physician, Dr. Richard Bartley Cattell, of the Lahey Clinic in Boston, is a former Ohioan.

* * *

Dr. Margaret O'Neal, Muskingum County health commissioner, and a member of the Committee on School Health of the Ohio State Medical Association, received recognition in an article entitled "Disease Detectives," which appeared in the May 30 issue of the *Saturday Evening Post.* The article tells how Dr. O'Neal dealt with a diphtheria outbreak in her area in October 1952.

Meat and its applicability in the Dietary Management of Atherosclerosis

Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3, 5]

Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

---

1. Hildreth, E.A.; Hildreth, D.M., and Mellinkoff, S.M.: Principles of a Low Fat Diet, Circulation *4*:899 (Dec.) 1951.
2. Bloch, K.: The Intermediary Metabolism of Cholesterol, Circulation *1*:214 (Feb.) 1950.
3. Keys, A.; Mickelson, O.; Miller, E.V.O., and Chapman, L.B.: The Relation in Man Between Cholesterol Levels in the Diet and in the Blood, Science *112*:79, 1950.
4. Gubner, R., and Ungerleider, H.E.: Arteriosclerosis, a Statement of the Problem, Am. J. Med. *6*:60, 1949.
5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation *3*:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. *10*:1 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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LESSONS FROM THE HAWLEY EPISODE

The Hawley incident created so much furore —primarily in medical circles—prior to the recent A. M. A. meeting in New York, that the restrained, but objective, action taken by the House of Delegates on the subject was refreshing, to say the least.

Dr. Hawley probably popped off too vigorously. At the same time, those who rushed into public print to criticize him only produced double publicity for the charges which he made against some members of the medical profession—some of which charges are pretty thin; others uncomfortably true.

In our opinion the following editorial in the *Cleveland Press* on the matter contains some sound logic and offers some good advice to the medical profession, emphasizing that the profession will win more public esteem by talking about the good things it is doing than by trying to alibi for criticism, even though the criticism may be in part unjustifiable:

"The American Medical Association acted wisely in refusing to throttle public criticism doctors sometimes level at those who violate the profession's stern code of ethics.

"The issue came up at the A. M. A. convention when several resolutions were introduced demanding official censure of Dr. Paul Hawley, head of the American College of Surgeons. Dr. Hawley has led an aggressive crusade against fee-splitting among doctors, and the performing of unnecessary operations.

"The A. M. A. didn't give Dr. Hawley an entirely clean bill of health. It expressed one regret over any 'loss of public confidence' in the profession that his crusade may have caused.

"But the organization did recognize and approve his right to smoke out the code breakers.

"And the doctors will find the public's knowledge that doctors, themselves, are working aggressively to enforce their rigid rules will build far more confidence in the profession than occasional revelations of wrongdoing will destroy."

BETTER VOLUNTEER NOW, YOUNGSTERS TOLD

The Army is reminding physicians completing their internships or residencies that it may be to their advantage to volunteer for Army medical service instead of waiting to be called under the "Doctor-Draft" act. While remuneration and rank may be the same whether these persons volunteer now or are notified later that they must serve, the Army's Surgeon General Office states: "The physician who volunteers at least knows the exact date that he is to enter the Army. Also he will not lose out financially during the several months interim between the time his civilian training has been completed and the date he comes into the Army." The service explains that any doctor interested in volunteering should communicate with the Army area headquarters in which he lives. Selective Service has estimated that about 3,000 physicians now classified in priorities 1 and 2 and those under 30 years old in priority 3 will be completing their internships or residencies this month.

EVIL DAY CATCHES UP WITH THE STATES

In our opinion one of the most important pieces of legislation now before the Congress, with the blessing of the Eisenhower administration, is the proposal to create a commission to study and evaluate the present abnormal relationship between Federal, state and local governments as regards responsibilities, tax sources, grants-in-aid, etc.

President Eisenhower has said: "I firmly believe that the army of people in America urging greater and greater centralization of government and greater and greater dependence upon the Federal treasury constitute a greater threat to this government than any combination of foreign forces that may be arrayed against us."

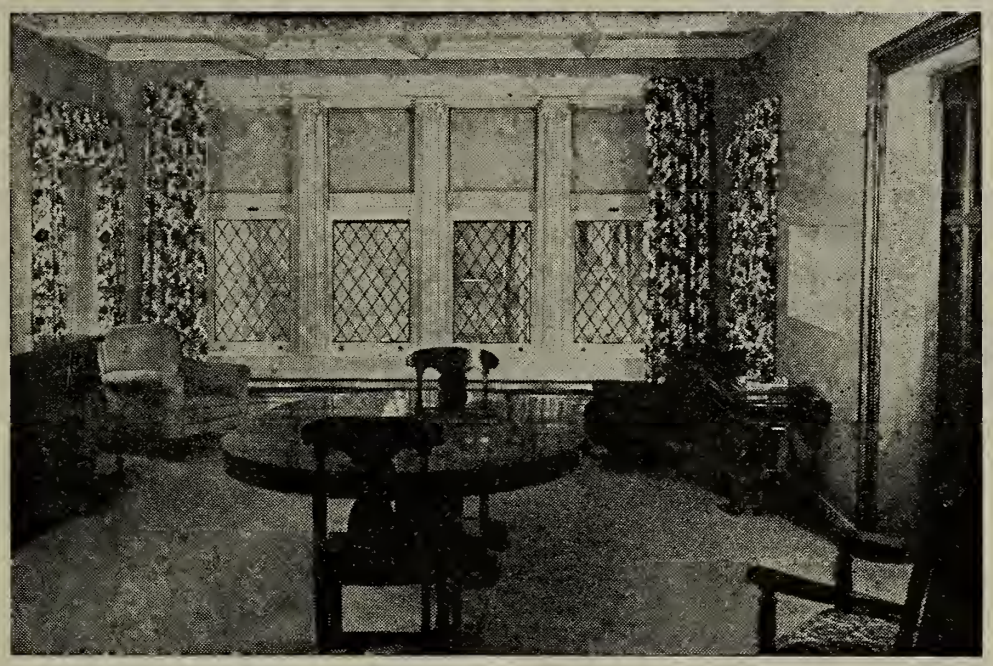
Until this big, over-all question is solved, state and local governments are going to be hamstrung and dominated by a powerful centralized government at Washington.

Look at the present public health situation. Ohio, and all the other states, have been dependent to a large extent on Federal funds for the operation of their public health programs. Some of them have been accepting these hand-outs gladly and without questioning the implications. In other instances, states which would like to do a better job themselves have been unable to do so because the Federal government has preempted the money-raising field.

Now, Washington has gone on a budget-cutting spree—probably with justification. The big cuts which have been made in funds for grants-in-aid to the states for public health work—if they stick—will produce tough-going for many of the states.

Ohio is a good example. Public health activities in Ohio will have to be curtailed considerably if the Federal cuts are made unless the executive

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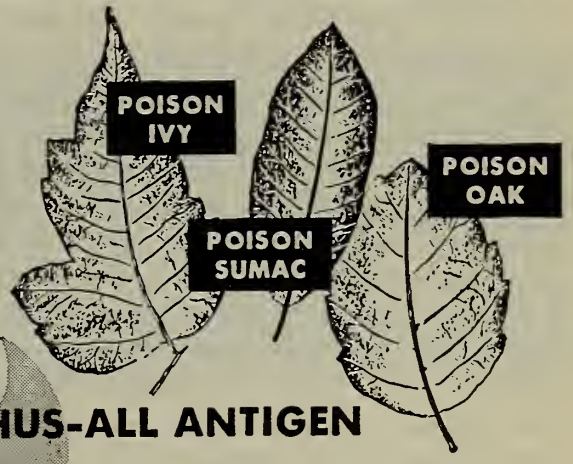
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_____Complimentary copy of "Handbook of Allergy for the General Practitioner."

DR._____

STREET_____

CITY_____ STATE_____

and legislative branches of the Ohio government see that the state department of health gets more money this biennium than in past years. About half the funds used to operate the department now are grants from Washington.

Representatives of the Ohio State Medical Association and others have been warning Ohio public officials for years that the evil day would catch up with them some of these days. Such warnings have fallen on deaf ears. Now there is a rush for the crying room and loud wails for help. It may be rough-going in the future unless state and local governments—and civic minded people—quit looking to and running to Washington for gift money and do a bit of knitting at home.

PARTIAL BLAME FOR "ALL THAT PAPER WORK"

Physicians often wonder why they continually face so much paper work.

The Commission on Financing of Hospital Care—a non-governmental agency—has come up with at least a partial answer.

It reported on a study of what is called "Third-Party Payments for Hospital Care." The third parties which are the subject of the report are those agencies which pay the hospital for services on behalf of a patient.

How many "third party" agencies exist?

Answer: At least 20,000.

There was one other interesting item in the commission's first progress report. It follows:

"In the five years between 1946 and 1951, the cost to hospitals for each day of patient care rose from a national average of $9.39 to $16.77—an increase of 79 per cent. How much of the increased cost of hospitalization is due to expanded services; how much to higher costs of labor and materials? That is a question for the commission to answer. By what means may costs be held to a minimum, through more efficient management, without impairing services? That is another item for the commission agenda."

DEPENDENT CARE STUDY LAUNCHED

Secretary of Defense Wilson has appointed a Citizens Advisory Commission on the Medical Care of Dependent Military Personnel and asked it to start immediately on a study of this problem. It is under instructions to report its findings and recommendations to Mr. Wilson "at the earliest practicable date."

The Commission will study all aspects of the controversial question of military medical care for dependents, including type and extent of care to be provided, categories of dependents eligible, and extent of facilities to be furnished by the Federal government for these purposes.

Chairman of the Commission is Harold G. Moulton, Ph. D., formerly president of Brookings Institution. Other Commission members are Thomas I. Parkinson, president of Equitable Life Insurance Co., of America; Lewis W. Jones, (Ph. D.), president of Rutgers University; Dr. George W. Bachman, senior staff member of Brookings assigned to health matters; and Mrs. Eugene Meyer, wife of the chairman of the Board of the Washington Post.

This is a study which is long over-due. The solution of this problem will have a far-reaching effect on the utilization of medical manpower during this critical period of world emergency. Moreover, the findings of the commission may well play a big role in the final decision as to just how far the Federal Government should or should not go in the field of medical care generally.

GOOD BOOKLET FOR YOUR WAITING ROOM TABLE

In our opinion, Ohio physicians would be helping a good cause if they would comply with the suggestion in the final paragraph of the following letter, received from W. R. Petrie, manager of advertising and promotion of the General Electric Company, X-Ray Department, Milwaukee 14, Wisconsin, for goodness knows any carefully worked out project which will help dispel the so-called mysteries of medicine and improve medical-public relations should receive a boost from the medical profession:

"As the X-Ray Department of General Electric, the lay magazine reader means nothing to us. He can express no preference for the type of x-ray equipment that will be used to diagnose or treat his ailments and he buys none for himself. Nevertheless, for the second year he is reading a series of our advertisements in *Newsweek* dealing with x-ray diagnosis and treatment. Why?

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"Although *Newsweek* will carry these messages to more than 850,000 serious readers, many of them leaders in their communities, additional thousands can be reached at a psychological moment if copies of this brochure were placed on reception room tables.

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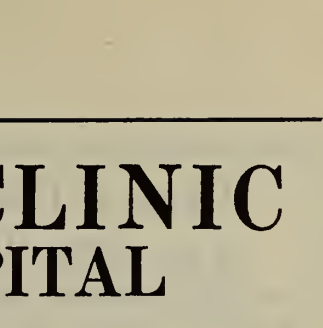
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Office Public Relations For the Busy Physician

Editor's Note: In order to provide tips for physicians in regard to good Public Relations procedures and practices in their offices, *The Journal* will present from time to time concise articles based on suggestions and recommendations made at A. M. A. Public Relations conferences and on articles published in other medical journals.

LET THE TRUTH PREVAIL

The thinking of a nation actually originates in the local communities. Hence, every doctor in the United States should be well informed concerning the real facts surrounding medical socio-economic problems in order that his patients may be correctly advised.

Currently, many misconceptions have developed concerning medical education, especially with regard to the production of more doctors.

Just off the press is the "Factbook on Medical Education," published by the American Medical Association and available without cost at A. M. A. or O. S. M. A. headquarters in quantities for distribution at the physicians' offices.

Some of the points emphasized in this handy little booklet are:

1. There are 72 medical schools and seven basic science schools in the U. S.

2. Total enrollment was 27,076 in 1951-1952, a record-breaker for the fourth consecutive year.

3. Enrollment has jumped 26.6 per cent during the past 11 years.

4. The 6,080 graduated in 1952 constitued the largest class ever graduated from medical schools on regular schedules.

5. The 1951-52 freshman class numbered 7,441, largest on record and a 27.5 per cent increase over the class of 1940-41.

6. From July 1942 to July 1952, the population increased 16.4 per cent while medical school enrollments increased 22.8 per cent.

7. Because of thorough screening by faculty admission committees, less than 15 per cent of all students in American medical schools are dropped during the entire four-year course.

8. Funds available to medical schools for their operations have increased 69 per cent during the past six years, without Federal subsidy.

9. Of the 79 medical and basic science schools in the U. S., 41 are privately owned, 35 are state owned, and three are municipally owned.

10. A study of medical school faculties in 1951 showed a staff of 15,563 teachers and research workers.

11. The state universities of Mississippi, Missouri, North Carolina, and West Virginia are expanding their basic science schools to four-year medical schools.

12. The University of California admitted its first freshman class in medicine in 1951, and the University of Miami (Fla.), in 1952. Yeshiva University of New York City is building a medical school.

13. New medical schools are being considered at the University of Florida, the University of Kentucky, and in Connecticut.

In summary, medical education, during the academic year of 1951-52 recorded these accomplishments:

The largest medical school freshman class in history.

The largest medical school four-year enrollment in history.

The largest graduating class, while on regular schedules, in history.

The greatest increase in teaching facilities in history.

The best financial support of medical schools in history.

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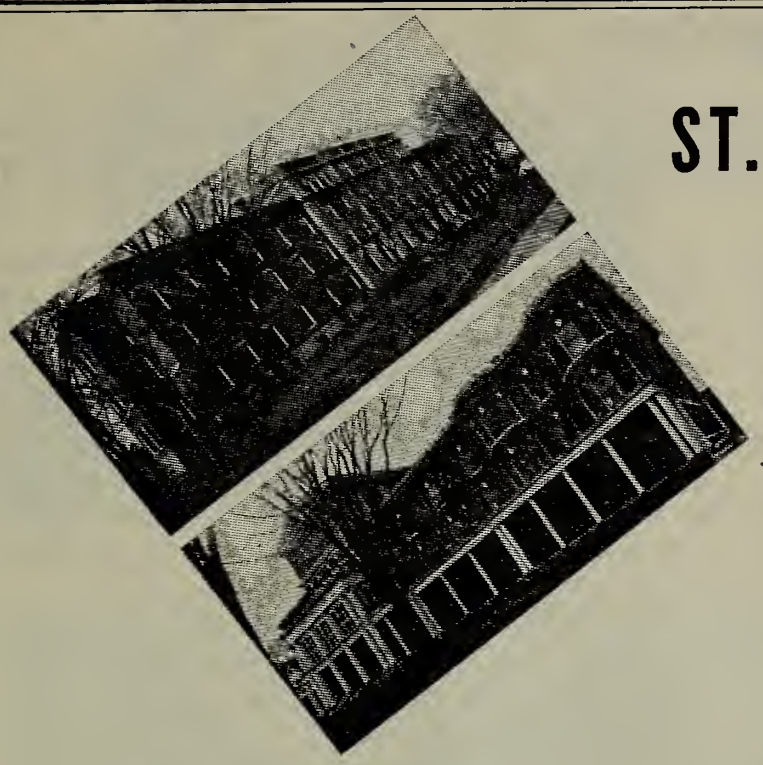
State and National Medical History Organizations Meet in Columbus

The Ohio Academy of Medical History, an affiliate of the Ohio State Archaeological and Historical Society, served as host to the American Association of the History of Medicine during its annual meeting at the Ohio State Museum on April 10-12. Seventy-seven delegates, from fifteen states, the District of Columbia, and Ontario, Canada, were in attendance. The joint sessions, with the exception of the annual dinner of the American Association of the History of Medicine, were held in the Arthur C. Johnson Memorial Auditorium at the Ohio State Museum.

During the course of the sessions of the Ohio Academy, Dr. Linden F. Edwards, the retiring president of the Ohio Academy of Medical History and professor of anatomy at the Ohio State University, presented honorary life-membership certificates to Dr. Frederick C. Waite, of Dover, N. H., and to Dr. Edward C. Mills, of Columbus, Ohio, for distinguished service.

At the annual business meeting of the Ohio Academy of Medical History the following officers were elected: Howard Dittrick, M. D., Cleveland, president; David A. Tucker, Jr., M. D., Cincinnati, vice-president. John O. Marsh, Curator of History, the Ohio State Museum, was reelected secretary and treasurer of the organization.

Members of the Ohio Academy of Medical History wishing to present papers at the next annual meeting, to be held in conjunction with the annual meeting of the Ohio State Archaeological and Historical Society in April 1954, should contact Howard Dittrick, M. D., the newly elected president, at 11000 Euclid Avenue, Cleveland.



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Getting Paid for Practice . . .

Medical Bureau Executive Discusses This Subject From a Business Point of View, and the Public Relations Problem That Goes With It

PHYSICIANS who face the age-old problem of getting paid for their services will find in the following article a store of material gathered from first hand experience in the field. Stanley R. Mauck, executive secretary of the Columbus Academy of Medicine and director of the Columbus Bureau of Medical Economics, has gained national attention for his practical discussions on this subject. This article is a transcript of a talk he gave at the 1953 Annual Meeting of the Ohio State Medical Association before the Section on General Practice.

* * *

An ancient cartoon portrayed the doctor in the likeness of an angel during the patient's critical illness; in the garb of an ordinary citizen during convalescence; and in the form of the devil on arrival of the bill.

This, of course, is a gross exaggeration of the doctor-patient relationship. It serves to emphasize, however, that getting paid for practice is an age-old problem.

I propose to discuss briefly what may be done to transform the physician from this Beelzebub concept, growing out of charges, to that of the respected healer of the sick who gets paid for practically all the services for which he has a right to expect payment.

Over a period of 19 years, in my dual capacity as Executive Secretary of the Columbus Academy of Medicine and Director of its affiliated business unit, I have learned much on both sides of the money problem in medical practice. I know the physician's angle and I also know it from the patient's standpoint. I understand the factors which often explain why some physicians have a more serious collection problem than others and why so much bad public relations is tied up with this problem.

REALISTIC FEE POLICY

The physician has every right to expect that people who pay for other services and commodities, who are self-supporting in all other areas of their economic relations, should also pay the fair and reasonable costs of medical care. Most such patients are honest and will pay their bills for medical care, the same as they pay all other bills. The problem of getting paid for practice could be greatly lessened by a realistic fee policy and proper attention to a few, simple, common sense rules of business procedure in the physician's office.

The first thing to note is that **not all** who receive medical care can or should be expected to pay. It is wasted effort in trying to collect fictitious book accounts from patients who can pay nothing. You can reduce your collection problem by limiting your charges to patients who can afford to pay. Render charity where charity is due, and don't kid yourself that you are going to be paid for it, unless, of course, you can be compensated by a private or public agency responsible for particular cases of the indigent. But don't bill the patient in these cases.

Not all charity cases can be spotted at the time of service, but more of them can and should be known for what they are, and handled accordingly. The needless effort made by physicians to collect from down-and-out patients is mere shadow boxing with a phantom collection problem which produces no money and merely serves to react most unfavorably against the whole profession.

THOSE WHO CAN PAY LITTLE

There are other cases where the patient can pay something but where the physician's usual charges are not fair or reasonable, in light of the patient's true financial situation. This unnecessarily creates an abnormal collection problem. We see this repeatedly in the operation of the collection service of our business bureau where a common complaint is heard that the charges are too high and more than the debtor can afford to pay. Many times this is merely a cover-up for refusal to pay perfectly legitimate bills. To many times, however, there appears to be some justification for the complaint.

This does not necessarily mean that the fees are out of line for Mr. Average patient; merely that they are difficult or totally impossible for some. Fees realistically assessed on the basis of known hardship situations will reduce the collection problem—and increase good public relations.

We made a careful sampling of the accounts in the files of the Bureau's Collection Department to find out why they were in our hands. A great many were found to be delinquent because of medical indigency, illness or other special circumstances, old age or because the family was on relief, and so forth.

Most of these probably should not have been charged anything. In other cases the debtors would have been able to pay reasonable amounts adjusted to their financial situation. Confronted with charges which, in their circumstances, looked like the national debt, they made little or no effort to pay—with the bills finally being turned over for collection. Our survey indicated that



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twenty-two per cent (22%) of our collection accounts fall in these two categories.

INFORMATION ON FIRST CALL

Failure to get adequate information about the patient on the first call, a simple business detail, is often to blame for some charges that should never have been made at all and for others that are totally out of line with people's ability to pay. It is not possible, of course, always to get this information, but a great deal could be accomplished if the physician or his secretary would try to find out more about the economic situation of certain patients.

Nothing is more conducive to bad public relations than to have bills of this character turned over for collection. They furnish the grist which feeds the mill that agitates for socialized medicine. **Much of the criticism about physicians' charges is due not to the fact that the fees are exorbitant for most patients, but that they are definitely so for others.**

CONSIDERATE AND BUSINESS-LIKE

Assuming you have carefully screened your patients to determine hardship cases and the indigent, it is then important to be considerate and business-like with those who are able to pay. Modern medical practice demands a different concept of the physician's business relations with his patients than prevailed in the horse-and-buggy days. **Today it is a breech of proper doctor-patient relationships to omit some of the factors which yesterday were considered unethical in medical practice.**

Discussion of the money problem with a patient, as an example, used to be taboo; now it is not only considered smart, business-wise, to talk over the problem of expense, as an aid to getting paid, but it is also important from a public relations standpoint. Grievance Committees point out that approximately ninety per cent of the complaints relate to fees. Most of them may not be justified, but a frank understanding about the amount of the charges, and the manner of payment, would prevent many unsatisfactory accounts and eliminate a lot of the gripes against the profession.

A discussion of the expense is particularly advisable when the over-all charges involve consultations, referrals to other doctors, hospitals, nurses, etc. The patient is entitled to know what to expect so he can plan necessary adjustment in the family budget, negotiate loans, or possibly make special arrangements with the physician for periodic part payments. Many potential collection difficulties are avoided by a sane business approach to the problem before it becomes serious.

FRANKNESS LEADS TO GOOD PR

Our years of experience in observing the financial aspects of medical practice, from both the physician and the patient standpoints, leads to this definite conclusion: **Physicians with the least collection problem and the best public relations are likely to be those who discuss charges frankly and sympathetically with the patients.**

It is significant to note the emphasis being placed by the A. M. A. on a full understanding between doctor and patient about fees and the payment of the costs of medical care. To encourage better handling of this problem, the dignified wall plaque "To All My Patients" is furnished by the Public Relations Department for the nominal cost of one dollar. Every physician should display this plaque in his office.

It is obvious that the physician should collect his accounts in his own office rather than through a collection agency. He thus saves a collection commission and avoids the bad reaction of some patients whose accounts are turned over for collection.

Fundamental to proper handling of the charge practice, so the physician can collect in his own office, are (1) simple but adequate records, (2) a systematic program of regular monthly statements, and (3) adequate follow-up of accounts which are not paid satisfactorily. By this procedure, getting paid for medical practice ceases to be a mystery and the physician's collection ratio will usually be 90 per cent or above.

PROMPT BILLING

Delayed initial billing is still a chronic weakness in many offices and is an open invitation to delinquent accounts. When the first statement arrives three, four or six months following service, the patient is not likely to be excited about prompt remittance. It is so easy to neglect a bill which was so long in arriving. It is unfair to the patient to stigmatize him as an irresponsible deadbeat if a check is not immediately forthcoming, under these circumstances. **The doctor's own business delinquency invites payment delinquency on the part of the patient.**

Also the physician's services now seem less important than when life was at stake or when pain and suffering were relieved. The urge to pay varies in inverse ratio to the distance from the date when service was rendered. Furthermore the amount now appears large and the money that might have been paid to the physician earlier has possibly been spent.

BILLS, BILLS AND THE DOCTOR'S BILL

Sporadic billing and little or no follow-up of slow accounts are in the same category with delayed initial billing. Everybody today receives bills regularly each month for everything under the sun. Mass production, installment buying and high-pressure advertising are responsible. If the physician's bill is not received along with

the others, he usually waits. And why not? The debtor can hardly be held responsible for slow payment if the physician has not made him conscious of the obligation and what is expected in the way of payment.

Furthermore, prompt and regular billing is essential as a means to establish a yardstick for determining what really is a delinquent account. An account may be "old" with reference to the date of service but it is "current" in the minds of debtors who have never been billed. Only if an account has been billed systematically, with appropriate follow-up after several plain statements, can it be said to be truly delinquent and subject to sterner collection effort.

LAST RESORT ONLY

The payoff in these situations, public-relations-wise, comes when the patient, lulled into indifference by the physician's unbusiness-like collection procedure, suddenly gets notice that his old account has been turned over to a collection agency. **An account should not be placed with any agency for collection, and it is an injustice to do so, unless and until the physician's own office is certain that it cannot be collected in any other way.**

I referred earlier to the analysis made by our collection department which revealed that 22 per cent of the accounts were charity or hardship cases. The survey also indicated that 41 per cent of the accounts had probably received inadequate handling in the physician's own office, factors such as delayed or irregular billing, incomplete data in setting up the account, charge not made to the responsible party, misunderstood services, and so forth. Many of these so-called bad accounts were not really bad accounts at all. Unquestionably a lot of them could have been collected at the source, if properly handled.

This laxity in the physician's own office stands as a severe indictment of the way many professional men handle the business side of medicine. It unnecessarily accentuates the problem of getting paid for practice, and also contributes to much of the profession's bad public relations.

THE DEADBEAT

Finally, we should recognize there are people who don't pay the physician, or anyone else, unless forced to do so. The physician has more of these than the merchant because he cannot select his patients on the basis of credit standing or economic status. He is pledged to minister to the sick without regard to the possible remuneration involved.

These willful deadbeats and irresponsible patients should be carefully determined, by the simple process outlined above, and dealt with accordingly. They should not receive "free" medical care by repudiation of their just obligations. To permit them to do so is unfair and a gross discrimination against other good-paying patients.

Therefore, the judicious use of a reliable collection service is advisable, not only to protect the doctor's financial interest, but also in fairness to the conscientious debtor who pays satisfactorily.

IN SUMMARY

Summarizing, we may say that getting paid for practice, and doing it within the framework of good public relations, involves these fundamental considerations:

(1) Screen patients carefully to determine the worthy poor, against whom no charges should be made, and the hardship cases deserving special consideration as to the amount of the charges or special payment arrangements.

(2) Discuss money matters frankly with patients where a financial problem is indicated, particularly where consultations and specialty services are involved.

(3) Observe simple and orderly business procedure in handling the accounts receivable problem in your own office as the best assurance of successful collection results.

(4) Spot the irresponsible debtor early and handle him accordingly, by use of an ethical and reliable collection service. But give due consideration to the patient who acts in good faith and pays to the best of his ability.

There is no deep mystery about getting paid for medical service which is rendered to those who can and should pay the fair and reasonable cost of such service. It is only necessary to recognize that patients are people, that they deserve to be handled as individuals rather than cases, and that by observing a few simple rules of business procedure your collections will be satisfactory and your public relations good.

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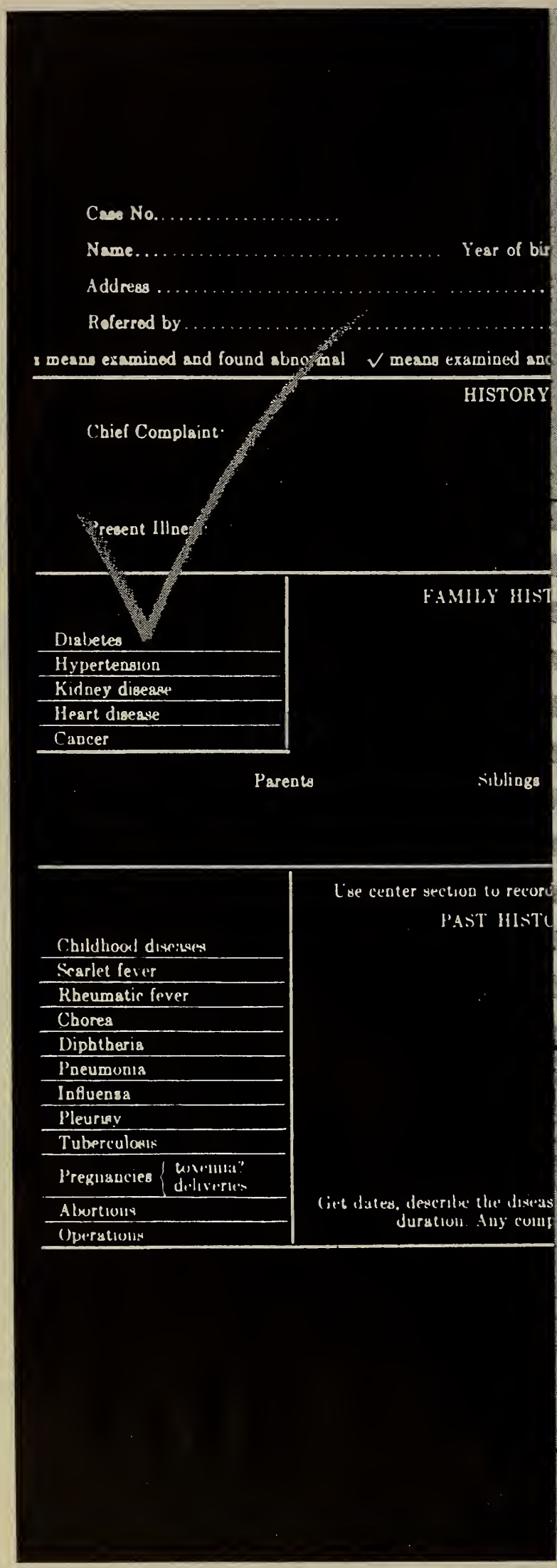
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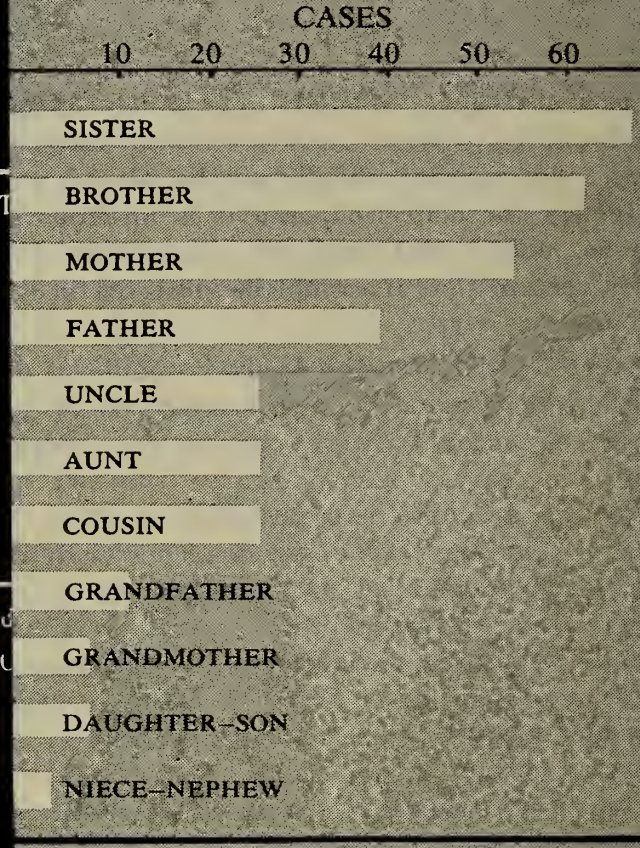
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1. Barach, J. H.: Diabetes and Its Treatment, New York, Oxford University Press, 1949, p. 38.
2. Allen, F. M.: Diabetes Mellitus, in Piersol, G. M., and Bortz, E. L.: Cyclopedia of Medicine, Surgery, Specialties, Philadelphia, F. A. Davis Company, 1951, vol. 4, p. 505.

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In Memoriam . . .

Arthur C. Bachmeyer, M. D., Cincinnati; University of Cincinnati College of Medicine, 1911; aged 66; died May 22; member of the Ohio State Medical Association and the American Medical Association; member of the American College of Hospital Administration. Dr. Bachmeyer, upon completion of his medical training, was named superintendent of the Cincinnati General Hospital and held that position until 1935. During much of that time he also served as superintendent of the Cincinnati Tuberculosis Sanitorium. He became dean of the University of Cincinnati College of Medicine in 1925 and served in that capacity until 1934. The following year he went to Chicago and was associated with the University of Chicago until his retirement last year. Dr. Bachmeyer received the Award of Merit of the American Hospital Association in 1943 and in 1944 was appointed director of the study of the Commission on Hospital Care. In 1948 he was named as vice-chairman of the Commission on the Survey of Medical Education and held that position until his death. He also was a member of the board and past president of the American Hospital Association and had been a member of the medical advisory committee of the National Security Resources Board since 1946. He also served in several other official capacities. A veteran of World War I, he held the rank in the Medical Officers of Reserve Corps of Lieutenant Colonel. He was affiliated with several Masonic orders. Survivors include his widow, a daughter and two sons.

Albert J. Bausman, M. D., Piqua; Medical College of Ohio, Cincinnati, 1895; aged 87; died May 26; member of the Ohio State Medical Association; member of the American Medical Association. Upon completion of his medical education, Dr. Bausman opened an office in Pleasant Hill and in 1913 moved to Piqua, where he had practiced since with the exception of time spent in postgraduate studies principally in New York and at the Mayo Clinic. He was a recipient of the Ohio State Medical Association's 50-Year Pin and Certificate. Affiliations included memberships in the Masonic Lodge and the Adventist Church. Surviving are his widow and his son, Dr. Joseph Bausman, with whom he was associated in practice.

Rollett A. Carson, M. D., Cleveland; University of Toronto Faculty of Medicine, 1922; aged 56; died May 23; member of the Ohio State Medical Association. Dr. Carson was a practicing physician in Cleveland from 1922. He was a member of the Masonic Lodge and the Mayfield Country Club. During World War I, he served with a Canadian Field Artillery unit. Surviving are his widow, a son and two brothers.

Joseph J. Dunn, M. D., Cleveland; Western Reserve University School of Medicine, 1900; aged 78; died May 19, former member of the Ohio State Medical Association, last in 1933. Dr. Dunn served all of his professional career in Cleveland, and had been honored by the Cleveland Academy of Medicine with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Catholic Church. Surviving are his widow, four sons and two daughters.

Robert K. Edler, M. D., Baltimore; Ohio State University College of Medicine, 1932; aged 55; died June 1; member of the Ohio State Medical Association through 1952; member of the American Society of Anesthesiologists. Before moving to Baltimore, Dr. Edler had been connected with the physical education departments at Otterbein College, Heidelberg College and Columbus Academy. Surviving are his widow, two daughters, two sons, his father and a brother.

Norman S. Green, M. D., Seattle, Wash.; University of Cincinnati College of Medicine, 1943; aged 40; died on or about June 1; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Green had done resident and staff work at Deaconess and Bethesda Hospitals in Cincinnati before he moved to Seattle only a short time before his death. Survivors include his widow, four children, his mother and a brother.

Isaac B. Harris, M. D., Columbus; Starling Medical College, Columbus, 1900; aged 80; died June 10; member of the Ohio State Medical Association; Fellow of the American College of Surgeons; president of the Columbus Academy of Medicine, 1926; delegate to the O. S. M. A. for several terms, and active on committees of the Academy. Dr. Harris served all of his professional career in Columbus, where he was outstanding as a private practitioner, as an educator and as a hospital staff member. In 1948, he was honored by St. Francis Hospital for 50 years service with that institution, having served an externship there before receiving his degree. He was chief of staff at St. Francis for many years. Later he was honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. An instructor on the staff of the old Starling-Ohio Medical College, he became assistant professor of surgery when O. S. U. College of Medicine was formed and later became professor of surgery. In 1946, he was named emeritus clinical professor of surgery. Dr. Harris worked hard in behalf of the O. S. U. Health Center. Affiliations included membership in several Masonic orders. Surviving are his widow; a son,

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Dr. William B. Harris, also of Columbus; two daughters, a sister and a brother.

Cyril C. Hussey, M. D., Sidney; Johns Hopkins University School of Medicine, 1919; aged 59; died May 9; member of the Ohio State Medical Association through 1949; secretary of the Shelby County Medical Society in 1922 and its delegate for several terms. Upon completion of his medical training, Dr. Hussey opened his office in Sidney, following in the footsteps of his father who also practiced there. He was in active practice there until health forced him to curtail his work about five years ago. He was a member of the Catholic Church. Surviving are his widow, three sons and two daughters.

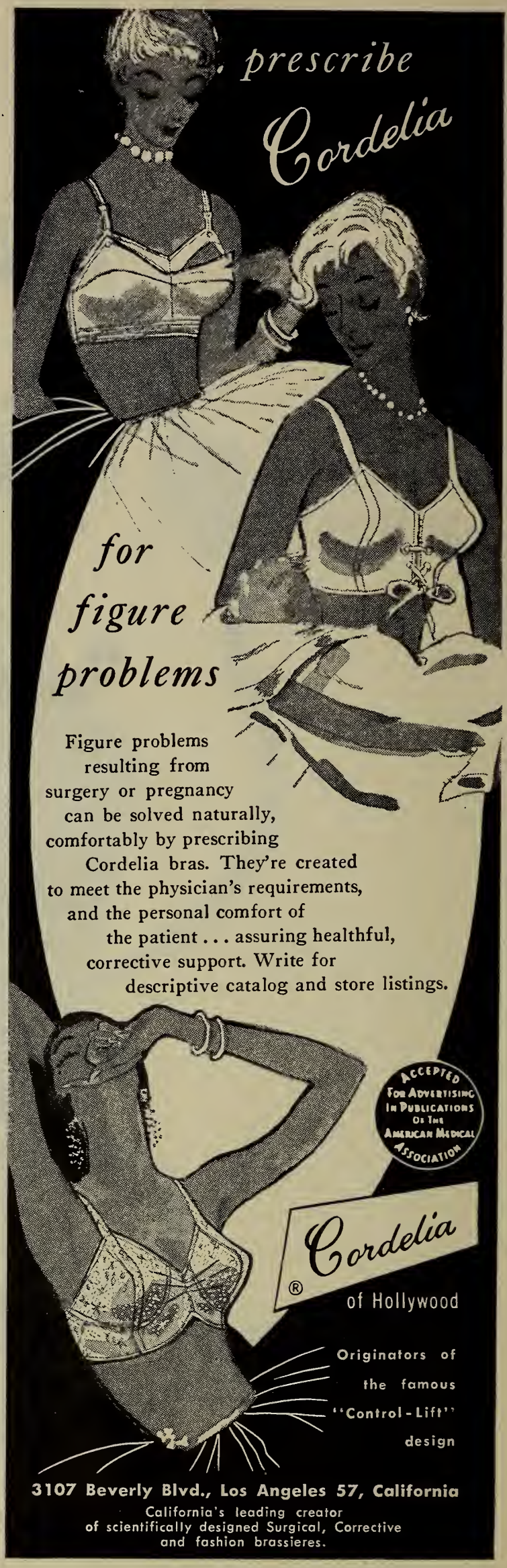
Clem D. McCoy, M. D., Kenton; Rush Medical College, University of Chicago, 1890; aged 88; died May 19; former member of the Ohio State Medical Association. Dr. McCoy practiced medicine for a number of years at Kenton and later moved to Texas where he continued practice. Upon his retirement he returned to Kenton. He was delegate of the Hardin County Medical Society to the O. S. M. A. in 1921 and alternate in 1923.

Bodo E. Miller, M. D., Akron; University of Michigan Medical School, 1911; aged 67; died June 3;member of the Ohio State Medical Association. Dr. Miller served all of his professional career in Akron, a total of more than 40 years, except for time served with the Medical Corps during World War I. Affiliations included memberships in the Masonic Lodge, the Methodist Church, and the Akron City Club. His widow and a sister survive.

John T. Murchie, M. D., formerly of Portsmouth; Rush Medical College, University of Chicago, 1921; aged 59; died May 26 in Ft. Lauderdale, Fla.; former member of the Ohio State Medical Association. Dr. Murchie had practiced for a number of years in Portsmouth before he retired in 1948 and moved to California; later moving to Florida. He was a member of the Catholic Church. His widow and a sister survive.

Edward Peterka, M. D., Cleveland; Western Reserve University School of Medicine, 1905; aged 73; died May 23; former member of the Ohio State Medical Association, last in 1947; Fellow of the American College of Surgeons. Dr. Peterka served all of his professional career in Cleveland, taking time out only for postgraduate work in Prague. Surviving are his widow and a daughter.

Arthur W. Shagrin, M. D., Cleveland; Western Reserve University School of Medicine, 1929; aged 48; died May 23; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Shagrin practiced for a short time in Youngstown before returning to Cleveland where he had received his training. During World War II, he served overseas with the



Army Medical Corps. Surviving are his widow and two sisters.

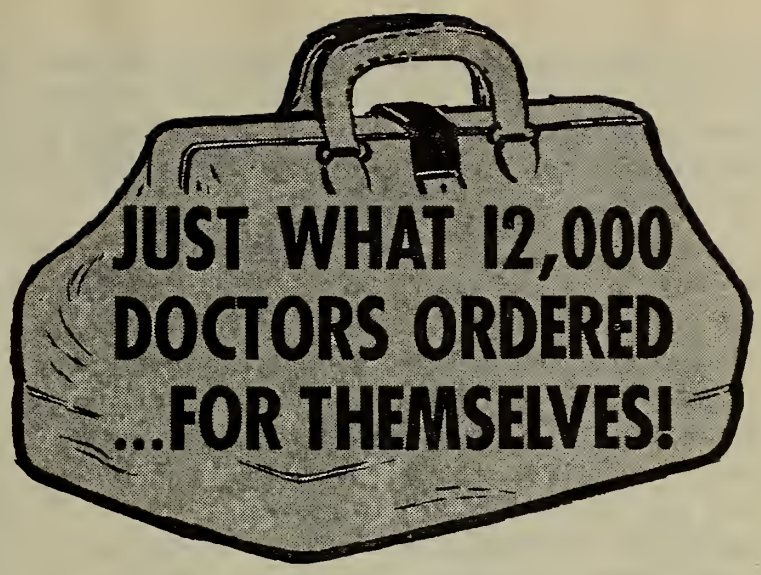
Alvin O. Sibila, M. D., Cleveland; Western Reserve University School of Medicine, 1917; aged 61; died May 12; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Sibila returned to Cleveland for practice after he had served in the Medical Corps during World War I. In addition to his practice, he was active in the Cleveland Public Health Association. Surviving are his widow, a son, a daughter and a brother.

Charles M. Siegel, M. D., Cincinnati; Marquette University School of Medicine, 1926; aged 52; died May 11; member of the Ohio State Medical Association; member of the American Medical Association; member of the American College of Chest Physicians. After receiving his medical degree, Dr. Siegel engaged in postgraduate work at Jewish Hospital, later joining the staff there. He began private practice about 1928. Surviving are his widow, a son, a daughter and three brothers.

Harry H. Stafford, M. D., Dayton; Ohio Medical University, Columbus, 1907; aged 77; died May 30; former member of the Ohio State Medical Association, last in 1947. Dr. Stafford was a practicing physician in Dayton for more than 40 years before illness forced his retirement several years ago. In addition to his professional work, he was active in several Masonic bodies and in the Evangelical and Reformed Church. Survivors include his widow; a son, Dr. Robert Stafford, also of Dayton; and two brothers.

Spencer A. Wahl, M. D., Cleveland; Western Reserve University School of Medicine, 1920; aged 57; died May 21 while on a trip in the east; member of the Ohio State Medical Association. Dr. Wahl had been a practicing physician in Cleveland for about 30 years. In addition to his practice, he was active in a number of medical and health programs. He was on the Board of Directors of the Cleveland Academy of Medicine and served as chairman of the Academy's Section on Obstetrics and Gynecology; also as chairman of the Committee on Health Education and as a member of the special committee on the constitution. He also served on the Committee for Occupational Planning of the Welfare Federation, and the Special Committee on Hospital and Medical Services, and was appointed to represent the Academy on the Board of Trustees of the Cleveland Hospital Service Association. Surviving are his widow, two sons, a daughter and his father.

William B. Young, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1894; aged 83; died May 22; former member of the Ohio State Medical Association, last in 1929. A practicing physician in Cincinnati for approximately 59 years,





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Dr. Young had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He formerly served on the staff of the Department of Obstetrics, University of Cincinnati College of Medicine.

Karl G. Zwick, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1903; aged 85; died May 30; former member of the Ohio State Medical Association, last in 1947; member of the American Academy of Dermatology and Syphilology; diplomate of the American Board of Dermatology and Syphilology. Dr. Zwick was born in Cincinnati and received his early education there. He continued his studies in Germany where he received several degrees including the Ph. D. On returning to this country, he worked with his father in the pharmaceutical business, later going to the Medical College of Ohio where he received the M. D. degree. He then practiced for a number of years in Switzerland, returning to Cincinnati after World War I. He practiced in Cincinnati until his retirement several years ago.

Activities of County Societies . . .

ADAMS

Dr. Frank H. Mayfield, Cincinnati, spoke on the subject, "Painful Lesions of the Neck and Shoulder Girdle," at the June 18 meeting of the Adams County Medical Society. The dinner meeting was held in the K. of P. Hall in Cherry Fork.

CUYAHOGA

Appointment of M. John Hanni, Jr., as assistant executive secretary of the Academy of Medicine of Cleveland was announced early in June by Dr. John H. Budd, president.

Mr. Hanni will assist H. Van Y. Caldwell, for 30 years executive secretary of the organization. Mr. Hanni graduated from Ohio Wesleyan University with high honors in 1949. He is a Phi Beta Kappa and received his master's degree from Western Reserve University in 1950.

For three years in the Air Force during World War II, he has had experience as assistant dean of men at Western Reserve and as assistant sales promotion manager of the Euclid Road Machinery Company.

HAMILTON

Fifteen physicians were honored with the 50-Year Pin and Certificate of the Ohio State Medical Association at the May 19 meeting of the Academy of Medicine of Cincinnati. Dr. Daniel E. Earley, President, presided at the meeting and Dr. David W. Heusinkveld, First District Councilor, presented the awards.

Those present to receive the awards were: Drs. George C. Altemeier, Ruth G. Bernheim, John A. Caldwell, Nora Crotty, Adolf Krakauer, Charles

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Graduate School of Medicine

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, two weeks, starting Aug. 3, Sept. 14, Sept. 28. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting Aug. 3. Surgical Anatomy & Clinical Surgery, two weeks, starting Aug. 17. Basic Principles in General Surgery, two weeks, starting Sept. 21. Surgery of Colon & Rectum, one week, starting Sept. 21. General Surgery, one week, starting Oct. 5. General Surgery, two weeks, starting Oct. 12. Thoracic Surgery, one week, starting Oct. 12. Esophageal Surgery, one week, starting Oct. 19. Breast & Thyroid Surgery, one week, starting Oct. 26. Gallbladder Surgery, ten hours, starting Oct. 26. Fractures & Traumatic Surgery, two weeks, starting Oct. 26.

GYNECOLOGY—Intensive Course, two weeks, starting Sept. 21. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 14.

OBSTETRICS—Intensive Course, two weeks, starting Oct. 5.

MEDICINE—Intensive General Course, two weeks, starting Sept. 28. Electrocardiography & Heart Disease, two weeks, starting Oct. 12. Allergy, one month and six months, by appointment.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 28.

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Maertz, C. W. Manss, Charles T. Perin, Edward C. Rosenow, J. Henry Schroeder, John E. Stemler and Ralph R. Wilkinson. Honored in absentia were Drs. Paul DeCourcy, Frank F. Ferris and George H. Knapp.

Officers elected are: Drs. Robert C. Rothenberg, president-elect; John R. Meek, secretary; Benjamin Hoyer, treasurer; Robert M. Woolford, trustee.

The officers will assume their offices at the first meeting of the Academy in the fall. At that time Dr. Dale P. Osborn will succeed Dr. Earley as president.

LUCAS

The Inter-Hospital Postgraduate Lecture Series, presented by the Medical Advancement Trust of the Maumee Valley Hospital, brought to Toledo Dr. Maxwell M. Wintrobe, professor of medicine, Utah School of Medicine and author of a widely used book on hematology.

On Tuesday he spoke on the following subjects: "The Development of Knowledge Concerning the Anemias"; "The Pathogenesis of Various Types of Anemia," and "The Diagnosis and Treatment of Anemia."

On Wednesday his subjects were: "Disorders of the Spleen and the Physiological Basis and Indications for Splenectomy"; "The Nature and Manifestations of Leukemia and Allied Disorders," and "The Management of Leukemia and Allied Disorders."

MONTGOMERY

The annual meeting of the Montgomery Medical Society was held on May 27 at the Wright-Patterson A. F. B. Officers' Club. Golf, tennis, swimming and other outdoor sports preceded the evening dinner and entertainment.

Speaker for the occasion was Dr. Melvin A. Casberg, assistant to the Secretary of Defense for health and medical matters, who spoke on the subject, "Physicians and the Armed Forces."

Also present and guests of the Society, were Major General Silas B. Hays, Deputy Surgeon General, U. S. Army; Rear Admiral W. P. Dana, representing the U. S. Navy Surgeon General, and Major General Harry C. Armstrong, Surgeon General, U. S. Air Force.

RICHLAND

Members of the Richland County Medical Society held their regular monthly meeting at Mansfield General Hospital, May 21. Dinner was served to 45 members and guests, after which there was a business meeting.

The program committee presented Mr. Robert Canary, chairman of the Division of Social Administration of the Ohio Department of Public Welfare, and Dr. W. E. Obetz, medical advisor for the Industrial Commission. Each speaker discussed various problems which arise in their

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SCIOTO

Dr. John Mueller, of the Hematology Department, University of Cincinnati College of Medicine, spoke on the subject, "The Anemias, Their Diagnoses and Treatment," at the June 8 meeting of the Scioto County Medical Society, at the Portsmouth General Hospital.

SUMMIT

Dr. Thomas Hale Ham, professor of medicine, Western Reserve University School of Medicine, was guest speaker at the June 2 meeting of the Summit County Medical Society on the University of Akron campus. His subject was "An Experiment in Medical Education at Western Reserve University." Dr. Ham described the experimental curriculum initiated with the freshman class at Western Reserve in the fall of 1952.

TUSCARAWAS

Dr. and Mrs. Robert Wolf were hosts to the Tuscarawas County Medical Society and Auxiliary at their summer home on June 17 for a picnic dinner and outing.

Activities of Woman's Auxiliary . .

By MRS. EDWARD L. VOKE, Chairman, Publicity Committee, 243 Hampshire Road, Akron 13, Ohio

President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House

Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima

Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

ALLEN

The April meeting of the Auxiliary to the Allen County Academy of Medicine was highlighted by a visit from the new state president, Mrs. N. M. Reiff of Washington Court House. Mrs. W. B. Light, at whose home the meeting was held, served tea to the group. She was assisted by Mrs. Charles H. Leech, Mrs. R. E. Bushong, Mrs. A. Frank Portmann, and Mrs. R. L. Tecklenberg. Mrs. A. M. Barone, the retiring president, and Mrs. C. H. Zinsmeister, the president-elect, poured.

At the May meeting, Mrs. Barone installed the new officers. They were: Mrs. Zinsmeister, president; Mrs. M. M. Sondeimer, president-elect; Mrs. S. J. Novello, vice-president; Mrs. R. G. Hendershot, secretary; and Mrs. H. G. Deerhake,

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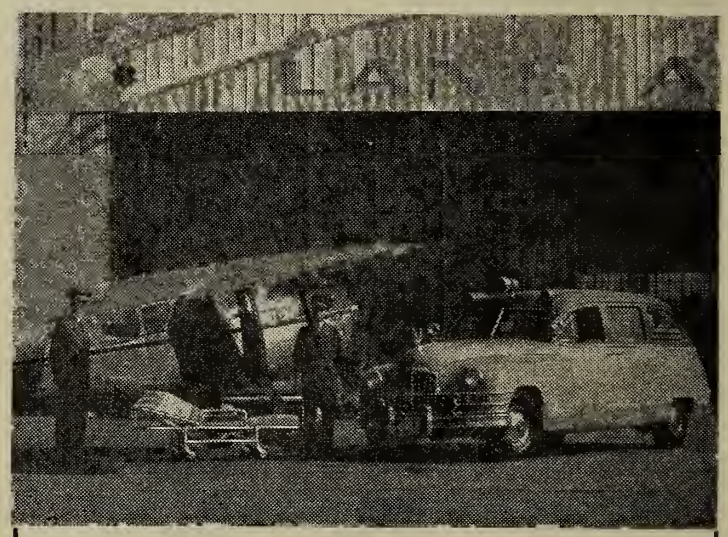
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treasurer. The meeting was held at the home of Mrs. F. Miles Flickinger, who was assisted by Mrs. A. A. Dalton, Mrs. R. J. Doernberg, Mrs. Deerhake, and Mrs. F. D. Rodabaugh.

AUGLAIZE

Mrs. A. W. Veit entertained the Auxiliary at her home for the May meeting. Mrs. Katherine Freck, Wapakoneta, entertained the group by telling of her tour in Europe last summer.

CHAMPAIGN

In the absence of the president, Mrs. F. R. Grogan, Mrs. F. E. Lowery conducted the May meeting of the Auxiliary. A report was given by the Auxiliary members who have been contacting donors for the next visit of the blood-mobile unit. Final plans were made for the tour to be taken by seniors from Urbana and St. Mary's high schools through Mercy Memorial Hospital.

On the sixth of May, this vocational tour was participated in by 90 seniors from these schools. Short talks on the various needs for young people in the hospital field were given by Dr. F. E. Lowery, medicine; Miss Antoinette Culley, x-ray; Sister Mary Bartholomew, nursing; Mrs. Grace Anderson, records and library work; Mrs. Helen Hubbard, dietary; Vic Vanscovy, engineering; Sister Mary Simeon, business office; and Guy Pepin, laboratory work. Members of the Auxiliary served as guides, furnished, and served refreshments at the conclusion of the tour.

ERIE

The husbands of the Auxiliary were entertained with a dinner party on May 13. The new president welcomed the guests. Following dinner, movies and square dancing were enjoyed by the group. Mrs. D. R. Lehrer, chairman of arrangements for the party, was assisted by Mrs. Fred Schoepfle, Mrs. W. R. Liebschner, and Mrs. R. S. Merrill.

FAIRFIELD

Mrs. Oscar Jepson, new vice-president of the Ohio State Medical Auxiliary, spoke before the Fairfield Auxiliary at the May meeting, when the new officers were installed. They were: Mrs. Fred Spangler, president; Mrs. A. B. Van Gundy, president-elect; Mrs. A. M. Kelly, vice-president; Mrs. S. C. Sneeringer, corresponding and recording secretary; and Mrs. C. T. Clark, treasurer. Mrs. W. D. Nusbaum, the retiring president, was presented with a gift of sterling silver by the members in appreciation for her services to the organization. Mrs. Nusbaum and Mrs. Jasper reported on the State Convention held in April. Hostesses for the meeting were Mrs. C. B. Snider and Mrs. A. B. Van Gundy.

FRANKLIN

Joseph Weisberg, pianist, furnished music for the final meeting of the Auxiliary. Mrs. William

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J. Miller was chairman of the luncheon arrangements, and was assisted by members of the Social and Telephone Committees. New officers installed were Mrs. Harve Clodfelter, chairman; Mrs. John Lowery, vice-chairman; Mrs. Henry B. Lacey, chairman-elect; Mrs. Martin Peter Sayers, recording secretary; Mrs. Phillip Hardymon, corresponding secretary; and Mrs. L. A. Kefauver, treasurer.

GREENE

Mrs. Richard F. Kelley was installed as the new president of the Auxiliary of Greene County at the May meeting. She succeeds Mrs. L. W. Sontag. Other officers elected were Mrs. S. C. Ellis, president-elect; Mrs. Gordon E. Savage, secretary; and Mrs. Paul F. McQuiggan, treasurer. Reports of the State convention were given by Mrs. Kelley and Mrs. H. C. Messenger. At the State meeting Mrs. Sontag served as chairman of the Resolutions Committee and was moderator of a panel discussion on *Today's Health*. It was voted to make the building and loan account available to the practical nurses' course at Greene Memorial Hospital. Mrs. Harold E. Ray announced that a tea for nurse recruitment was to be held May 15.

HAMILTON

At the May meeting of the Auxiliary, Mrs. Robert H. Kotte was installed as the new president. She succeeds Mrs. William H. Lippert. The program was heard at the farm home of Dr. and Mrs. Harold F. Downing. Mrs. Downing, who grows 152 varieties of herbs, spoke on "Pattern Herb Garden." Mrs. Richard W. Velter was the installation officer.

LICKING

Mrs. Ralph Pickett, the vice-president and program chairman, received suggestions concerning the program for the coming year, at the May meeting of the Auxiliary. The members participated in the recruiting of blood donors the recent visit of the bloodmobile unit.

LOGAN

The last meeting of the year was held at the home of the president-elect, Mrs. Warren F. Mills, Bellefontaine. Mrs. John L. Maurer, West Liberty, retiring president, conducted the meeting. Mrs. A. J. McCracken reviewed the April number of the magazine *Today's Health*. Members of the Auxiliary sponsored a tea at the Mary Rutan Hospital for senior girls of Bellefontaine and Logan County High Schools. Forty-five young women enjoyed a tour of the hospital under the direction of Mrs. Mary Jo Elswick, supervisor of nurses. Mrs. Douglas Beach of the Auxiliary and Mrs. Vaughn Young, member of the hospital staff, who talked to the guests, were introduced by Mrs. John L. Maurer, outgoing president. Punch



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and cookies were served. Mrs. J. P. Harbert presided.

LORAIN

Mrs. S. C. Lind, Cleveland, immediate past editor of *The Ohio Medical Auxiliary News*, installed the new officers of the Lorain County Auxiliary at its last meeting of the year. Mrs. T. E. Finegan will be the new president; Mrs. A. J. Novello, president-elect; Mrs. G. J. Krupp, vice-president; Mrs. R. E. Hayes, recording secretary; Mrs. N. E. Basinger, treasurer, and Mrs. C. T. Rusin, corresponding secretary. Mrs. G. R. Wiseman, retiring president, was presented a gift on behalf of the members by Mrs. Stanley J. Birkbeck, program chairman. Mrs. Finegan named as her chairmen, Mrs. Krupp, program; Mrs. M. C. Kolczun, membership; Mrs. D. A. Radefeld, finance; Mrs. Franz Gruen, social; Mrs. V. A. LaFleur, Lorain, and Mrs. Gordon Smith, Elyria, publicity; Mrs. John L. Sullivan, historian.

Mrs. G. E. Kingsley, public relations; Mrs. T. L. Smith, *Today's Health*; Mrs. R. T. Thomas, legislation; Mrs. Theodore Berg, Elyria and Mrs. Paul Kopsch, Lorain, sunshine; Mrs. H. E. McDonald, credit and awards; Mrs. R. M. Arnold, radio and visual education, and Mrs. William Lord, nurses' loan fund.

LUCAS

In New York City Mrs. E. Benjamin Gillette, a national director of the Auxiliary to the American Medical Association participated in the Auxiliary's 30th Annual meeting. Mrs. A. Paul Hancuff, who was elected president-elect of the State Auxiliary at the annual meeting in Cincinnati, also attended the New York meeting.

The Lucas County Auxiliary is offering a $300.00 scholarship, a full year's tuition at a Toledo Hospital nursing school for the first time this year. Directors of nursing of the various hospitals have been asked to select representatives to compete for this award. The prospective nurses selected will take the nursing tests offered at the University of Toledo and the winner will receive the award. The committee headed by Mrs. L. S. Pugh, includes Mesdames I. W. McConnell, Martin Lorenzen, George Bates, J. L. Westhaven, and John Burnett.

New officers were elected and installed at the annual spring luncheon. Annual reports and a resume of the State Auxiliary meeting were given. The University of Toledo players presented the program. Mrs. David Katchka was social chairman; and Mrs. Hazen Hauman, chairman of the nominating committee. Mrs. Henry Brunsting was program chairman.

The officers for the coming year are Mrs. Boni E. Petcoff, president; Mrs. Edward L. Burns, president-elect; Mrs. Edward L. Doermann, recording secretary; and Mrs. E. L. Gaspari, corresponding secretary.

Tribute was paid to Mrs. William J. Gillette, widow of a Toledo physician and the mother of four doctors, and grandmother of one physician and one medical student. Her picture was taken for the local press with her four daughters-in-law, Mrs. Morris W.; Mrs. Edward P.; Mrs. E. Benjamin; and Mrs. Robert S. Gillette. The Auxiliary thanked Mrs. Gillette for her work in its behalf.

MAHONING

Mrs. W. O. Mermis, retiring president, read a paper on the history of the National organization at the annual meeting of the State Auxiliary in Cincinnati in April. Mrs. William E. Maine, an alternate delegate, was appointed chairman of visual education for the State Auxiliary, and Mrs. Craig Wales, the state civil defense chairman, was re-appointed. Mrs. Morris Rosenblum, president-elect, attended the meeting as a delegate with Mrs. Mermis, the president.

At the April meeting, Mrs. Ivan C. Smith was elected as the new president-elect. Other officers chosen at this meeting were Mrs. Stephen Ondash, vice-president; Mrs. Charles Stertzbach, recording secretary; Mrs. Asher Randall, corresponding



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secretary; Mrs. George Cook, Treasurer. Mrs. Arthur Rappaport and Mrs. Edward Beynon were chairman and co-chairman for the meeting with Mrs. Frederick S. Coombs in charge of the program. Robert Hay, local director of Civil Defense, was guest speaker and described his recent experiences while attending atomic test projects in Nevada.

OTTAWA

The May meeting of the Auxiliary was held at the home of Dr. and Mrs. Shortridge in Oak Harbor. Mrs. Shortridge served as delegate with Mrs. George Boon, as alternate, at the State Convention at this meeting. Mrs. W. R. Gibson was named the state chairman of public relations. It was reported at the meeting that the group had helped the local society with funds towards the purchase of a movie projector. Newly elected officers were: President, Mrs. James Rhiel; president-elect, Mrs. Jack Witker; secretary, Mrs. Duffenbach; treasurer, Mrs. George Boon. Miss Florence Specht, hospital superintendent, was a guest.

SANDUSKY

Mrs. Allen Newman was elected president at the April meeting held at the home of Mrs. E. C. Swint. Mrs. Lloyd Drossell is president-elect, and Mrs. Swint was appointed treasurer. Mrs. W. J. Martin continues as secretary. Mrs. Frank Visconti reported on the State Convention.

TRUMBULL

Mrs. George A. Sudimack, the vice-president, conducted the April meeting in the absence of the president. A contribution was given the local cancer fund. "White Elephants" brought by the members to the meeting were given as prizes for the Bingo games which provided the entertainment. Mrs. M. T. Knappenberger, Sixth District Director, and Mrs. Joseph A. Ralston, delegate for the Auxiliary attended the State Convention. The Auxiliary held a combined dinner meeting with the Medical Society for its final meeting of the year. Dr. W. G. Srodes, assistant professor of Psychiatry at the University of Pittsburgh, was the speaker and his subject, "Psychosomatic Medicine." After the program, Mrs. Sudimack installed the new officers. They are Mrs. M. J. Crowe, president; Mrs. J. A. Ralston, president-elect; Mrs. C. M. Stone, vice-president; Mrs. G. A. Sudimack, treasurer; Mrs. A. L. Williamson, secretary. Mrs. M. J. Crowe was elected to serve as a delegate to the National Convention in New York City in June. A contribution was made to the County Home for the purchase of recreational equipment.

(Editor's Note: Additional Auxiliary county notes, submitted for this issue, were omitted because of limited space.)

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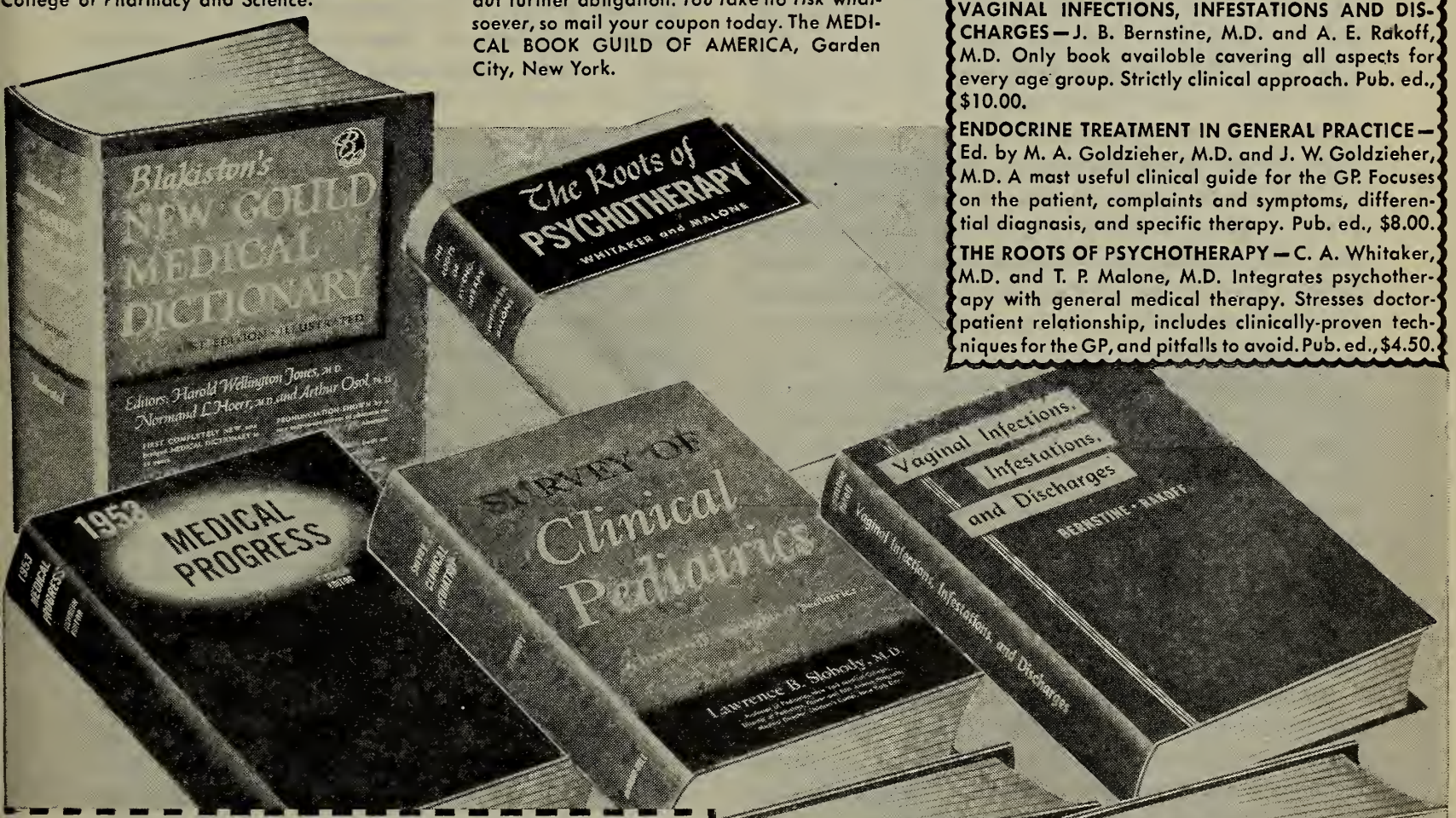
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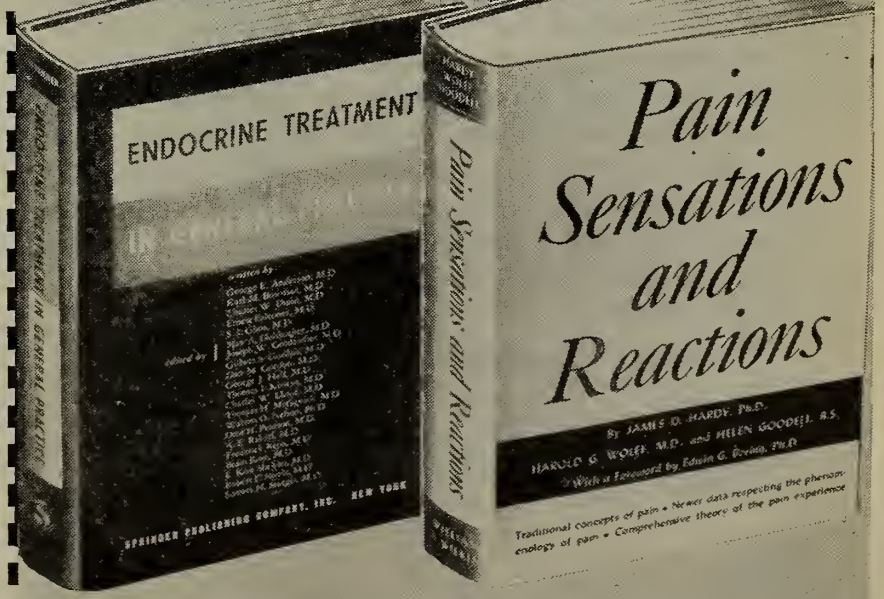
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Don't Be Afraid of Your Child, by Hilde Bruch, M. D., ($3.75. *Farrar, Straus & Young, 101 Fifth Ave., New York 3, N. Y.)*. The author, a psychiatrist and pediatrician, gives parents a new faith in their own judgment. She condemns the modern stereotyped psychologic approach to the upbringing of children. By reinterpreting the background of changing child care methods, the author goes a long way toward helping the parents who will read her book to develop a sounder perspective and philosophy of parenthood and its responsibilities.

Family Home Medical Guide, by Grover Nelson Gillum, M. D., D. O., F. A. C. N., ($1.00. *Wilcox & Follett Publishing Company, Chicago 5, Ill.)*

Functional Neuroanatomy, by Wendell J. S. Krieg, Ph. D., Professor of Anatomy, Northwestern University Medical School, ($9.00. 647 pages. *Blakiston Company, Philadelphia 5, Pa.)*. The lucid and readable text and the remarkably clear three dimensional drawings by the author illustrating this second edition of an important book should be of interest to clinicians generally as well as to those in the special field of neurology. The technical progress in brain localization, particularly in the thalamus and the brain cortex, in the ten years since the publication of the first edition of this authoritative work is clearly shown.

The Recurrent Dislocation of The Shoulder, by James A. Dickson, Alfred W. Humpheries and Harry W. O'Dell, ($4.50. *Williams & Wilkins Company, Baltimore, Md.)*. Hippocrates recommended plunging a red hot iron into the axilla. In this work we have a well organized and complete description of the condition and its modern surgical treatment by the distinguished members of the staffs of The Cleveland Clinic and The Akron Clinic.

Biology and Language, by J. H. Woodger. The Tarner Lectures for 1949-50 ($8.00. *Cambridge University Press, New York 22, N. Y.)* These lectures were designed to serve as an introduction to the methodology of the biological sciences including medicine. In Part I is explained the structure and classification of biological statements; in Part II the results as applied to genetics. In Part III he shows how a workable, partly symbolic language can be constructed for neurology and allied subjects which will clarify certain obscurities which have been a source of controversy.

Scientific Principles In Nursing, by M. Esther McClain, ($3.50. 2nd Edition. *C. V. Mosby Co., St. Louis, Mo.)*. The appearance of a second edition within two years speaks well for this text.

Pheochromocytoma and The General Practitioner, by Joseph L. DeCourcy, M. D., and Cornelius B. DeCourcy, M. D., ($4.00. *DeCourcy Clinic, Cincinnati 2, Ohio)*. A timely consideration of this "great mimic" among hypertensive disorders deserves careful reading by all who concern themselves with patients with such disorders.

Grow Health, Youth and Beauty With Me, by Dortch Campbell, ($2.50. *Dorrance & Company, Philadelphia 6, Penna.)*, promotes the spiritual side and through self discipline attempts to become healthier and younger every day in every way.

The Scientists Look at Our World, Edited by John M. Fogg, Jr., ($3.00. *University of Pennsylvania Press, Philadelphia 4, Penna.)*, presents the latest series of "Benjamin Franklin Lectures." President William V. Houston of Rice Institute gives a most interesting "Description of the Physical World." W. Albert Noyes, Jr., head of Chemistry at Rochester, describes the various modern uses of chemistry. Curt Stern, formerly professor of Zoology at Western Reserve University, and now editor of Genetics, writes on "Genetics and the World Today." Alan Gregg, the director of Medical Sciences for the Rockefeller Foundation has a fascinating lecture on "The True Outwardness of Medicine." It is a call for public cultivation of the medical sciences. But our greatest concern should be for the conservation and replenishment of our forests and croplands. Wendell H. Camp, President of the American Horticultural Council, in a brilliant resumé of "Plant Sciences in the World Today" summarizes our progress in furnishing a balanced diet, adequate clothing and comfortable shelter for all peoples, and the help that this branch of science gives us to work with in the future.

Synopsis of Pathology, by W. A. D. Anderson, M. D., ($8.00. 3rd Edition. *C. V. Mosby Co., St. Louis 3, Mo.)*. The comprehensive character of modern pathology is indicated by these 770 pages. An attempt to get a concise presentation of the information which may be obtained by morphologic, microbiologic, microscopic, chemical, serologic and other types of laboratory examinations on material obtained from a human body, in life or death, runs into a really sizable book although only a synopsis.

Unquiet Minds: Leaves from a Psychologist's Case Book, by Eustace Chesser, ($3.50. *Roy Publishers, New York 21, N. Y.)*. Here the author of **Love Without Fear** resorts to the case history method of instruction to enliven and point up his teachings.

Laboratory Technique in Biology and Medicine, by E. V. Cowdry, ($4.00. Third Edition. *Williams & Wilkins Co., Baltimore, Md.).* There have been great advances in laboratory procedures since the last edition was published in 1948 and they are all recorded in this new edition of this standard text.

The East-West Book of Rice Cookery, by Marian Tracy, ($2.95. *Viking Press, Inc., New York 17, N. Y.).* Here will be found 150 international recipes from a banquet as rich and elaborate as a Dutch East Indian Rijsttafel to the simple one dish meal of a Balkan soup. The allergist and others who are seeking to use the versatile and inexpensive grain will find the author's dishes unusual and easy to prepare, delicious and equally easy on the family budget.

Operative Neurosurgery, by Elisha S. Gurdjian and John E. Webster, ($10.00. *Williams & Wilkins, Baltimore 2, Maryland).* Here one will find the pertinent anatomic diagnostic and technical facts necessary for the execution of certain operative procedures. While the general subject of neurosurgery has been covered, emphasis has been put on surgical procedures involved in the management of trauma.

The Second Annual Report on Stress, by Hans Selye and Alexander Horava, ($10.00. *ACTA Inc., Medical Publishers, Montreal, Canada).* Certainly no concept in medicine has infiltrated the thinking of all of us as much as Selye's on Stress. As a promotional effort, this business of giving the profession an annual volume abstracting and summarizing the yearly literature to which the concept has given rise, cannot be beaten. On the other hand, we all do appreciate the help that this and the **First Report** have been in correlating the literature and thus helping us too as a guide.

Children of Divorce, by J. Louise Despert, M. D., ($3.00. *Doubleday & Company, 575 Madison Avenue, New York 22, N. Y.).* Here a well known child's psychiatrist on the staff of The New York Hospital, tells how to help one's self and one's children through the special crises and everyday problems of divorce.

Scalpel and Cross in Honan, by Casper C. Skinsnes, M. D., ($3.50. *Augsburg Publishing House, Minneapolis 15, Minn.).* Here, in his own words, is the life story of a veteran medical missionary to China. This autobiography rich in gripping personal stories will help the reader to understand China and the Chinese better.

Physiologic Approach to The Lower Animals, by J. A. Ramsay, ($2.75. *Cambridge University Press, New York 22, N. Y.).* This is an important work. It begins at the beginning and defines the general problems that face every animal and then goes on to show how these problems have been met at various levels of structure and organization.

Your Child and His Problems: A Basic Guide for Parents, by Joseph D. Teicher, M. D., ($3.75. *Little, Brown & Co., Boston 6, Mass.),* is a practical handbook dealing with all phases of child behavior. Best of all is the emphasis placed on the parents' own psychological problems which can profoundly affect the developing child.

Nutrition in India, by Dr. V. N. Patwardhan, ($5.50. *The Journal of Medical Sciences, Bombay 4, India).* This book summarizes the research in nutrition which has been going for the past 40 years. Here we learn about the common foodstuffs of India, the native diets, the nutritional status of Indian children and the incidence of apparent deficiency states.

While one cannot use our own figures as to food requirements among the Indians, it is apparent that with the best of planning and no obstacles India cannot feed herself. She can do a great deal better than she is doing but disease and pestilence must still be the main factors in population control. As we here in the United States move steadily to a vegetarian diet with less and less milk per person, it will repay those who are interested to study this popularly phrased report.

Marriage, Morals, and Sex in America, by Sidney Ditzion, ($4.50. *Bookman Associates, 34 East 23rd Street, New York 10, N. Y.),* is a history of the ideas about the subject from colonial times to the present. The book provides even the lay reader with a definitive review of American thought on the sexual code in all stages of our history. The author points out that one thread runs through all of the reform movements and this was the desire to attain an equitable balance of power between the sexes and above all a more satisfying expression of sexuality for both sexes. We physicians have not been as helpful to society as our experiences would qualify us to be. It is in our consultation rooms that the conflict between the over-sexed male and the undersexed female is revealed in its full social significance. We have a culture designed at every step to suggest sex to the male and stimulate him while we teach the other sex that it is only a function of procreation.

The Mechanisms of Disease: A Study of The Autonomic Nervous System, The Endocrine System and the Electrolytes in Their Relationship to Clinical Medicine, by Joseph Stambul, M. D., ($15.00. *Froben Press, 1776 Broadway, New York 19, N. Y.).* This is a scholarly arrangement of an immense amount of material that would take almost a lifetime to accumulate. It deals with the intricacies of the chemistry, biophysics and physiology of animal cells as they are affected by disease or play the role in it. All this is aimed to help to maintain the functioning of the human body within the biologic norm.

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JONATHAN FORMAN, M. D., *Editor*

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Typhoid Fever—A Latent Threat

SAMUEL SASLAW, M. D., Ph. D.

ALTHOUGH typhoid fever is no longer the scourge of earlier years, it has not become insignificant today. Modern methods of protection against contamination of water and food supplies have been particularly valuable in urban areas. However, when vigilance is relaxed, particularly in rural areas, typhoid appears. An uncomfortably large number of asymptomatic carriers freely circulating in our midst serve as a potential source of infection.

That the disease is still with us is demonstrated by the 556 cases reported in Ohio during the past five years (1948-1952) with an average of 111 cases per year; the national average is about 3,000 cases per year. Although in general the control of typhoid fever in the United States has been excellent it is still prevalent in many parts of the world. Thus, travelers, military personnel and immigrants may introduce additional carriers, who in turn, can serve as sources of epidemics.

SYMPTOMS AND SIGNS

Typhoid fever, since it is less common today, presents a greater challenge in diagnosis and prevention of spread, particularly when it occurs sporadically in non-epidemic form. The incubation period varies from three days to three weeks. The onset of disease is usually gradual and insidious with headache, malaise and anorexia for several days before the patient is forced to go to bed. Less commonly during the first several days there may also be associated cough, vomiting, diarrhea or constipation. On the other hand, in about 20 per cent of cases the onset may be abrupt with a chill or epistaxis.

From the Department of Medicine, Ohio State University.

The Author

● Dr. Saslaw, Columbus, is associate professor of Medicine and Bacteriology; assistant professor, Department of Preventive Medicine, Ohio State University, and director of Infectious Disease Service, University Hospital.

During the first week there is increasing fever with associated toxicity, sluggishness and periods of mental confusion. Rose spots may appear at any time during the disease and consist of small pale-red papules 2 to 5 mm. in diameter and are most commonly seen on the abdomen and lower chest.

Anorexia is very prominent during the early part of the disease as is constipation (approximately 50 per cent). When and if diarrhea occurs (17 per cent) the prognosis is worse since it usually implies ulceration in the colon. Abdominal distention is extremely common and pain and tenderness in this area is elicited in over 50 per cent of cases.

Bronchitis occurs in about 25 per cent of patients with a cough productive of mucoid sputum and rales are heard over the large bronchi.

Relative bradycardia is the rule in early stages but the heart rate may become rapid in the seriously ill or during complications. The blood pressure is usually low, and transient increases of the PR interval with changes in the T wave may be found in electrocardiograms.

Headaches are prominent during the first week or two and are often accompanied by pain in the neck or shoulders or retrobulbar pain. The con-

fused or maniacal state early in the illness is frequently accompanied by psychotic symptoms.

The spleen may be palpable in about half the cases and is usually soft and only slightly tender although the patient may complain of aching pain in the splenic area. Gurgling on palpation over the caecum is a classical sign of typhoid, but is also common in early bacillary dysentery and other intestinal infections. Abdominal tumidity, however, is a constant sign and is accompanied by a sensation of "doughiness" as in tuberculous peritonitis.

PROGNOSIS

Six features augur a very severe illness:

(1) Morning temperatures above 103°F.;
(2) Dry and cracked tongue;
(3) Meteorism;
(4) Diarrhea, especially if severe;
(5) The "typhoid state" with mental disturbance, incontinence and marked weakness;
(6) A rapid pulse early in disease.

LABORATORY EXAMINATION

In order to obtain maximum benefit from the laboratory the pathogenesis of this disease should be kept in mind. When the typhoid bacilli are ingested in sufficient quantity to cause disease they penetrate the intestinal wall and collect in the lymphatic nodules (Peyer's patches). If immunity is lacking or insufficient, the organisms enter the blood stream intermittently until enough immunity develops to confine the organisms again in the intestinal lymph nodes, as well as in the other reticuloendothelial tissues of the body. Thus, most satisfactory results are obtained by culture of the blood and feces.

During the first week of the disease blood cultures may be positive in 90 per cent of the patients, 70 per cent in the second week, 60 per cent the third and 40 per cent the fourth. Three or four repeated blood cultures taken at 30 minute intervals during the temperature rise on the first day of observation will frequently be fruitful and allow therapy to be instituted without further delay. Stool cultures are positive in about 50 to 60 per cent during the first, second and fourth weeks and 80 per cent during the third week. Repeated rectal swabs provide excellent results, particularly when constipation is present.

The agglutination test is of most value when a rising titer can be demonstrated. The peak development of antibodies begins during the second week and continues to rise thereafter although specific therapy may occasionally supress or delay the antibody response. It must be remembered that the "H" agglutinins persist longer in immunized persons and may also be affected by other febrile diseases. Thus the interpretation of agglutination results for typhoid must be made with due consideration of previous immunizations.

The titer against the O (somatic) antigen is of more significance in diagnosis since following immunization, O agglutinins fall to a low titer in about six months and are usually absent in a year. On the other hand the H (flagellar) agglutinins may persist for several years. If serial specimens are not obtained, a single specimen taken by the seventh to tenth day of disease showing an O titer of 1:50 or above in a person not vaccinated during the past year or two suggests infection. However, both in vaccinated and nonvaccinated individuals serial specimens should be obtained if possible. Therefore, the "O" agglutination titer is of greater significance. However, it must be remembered that antigens may vary from laboratory to laboratory and frequently are misleading; false positive agglutinations may occur in patients not having typhoid fever.

The leukocyte count is usually within normal limits but an absence of eosinophils is strong evidence in favor of typhoid fever. Albuminuria may occur in about 50 per cent of patients.

COMPLICATIONS

Intestinal hemorrhage is the most frequent complication and occurs in about 7 per cent of patients whether receiving specific therapy or not. It may be symptomless or be accompanied by varying degrees of abdominal pain.

Intestinal perforation may occur in 2 to 3 per cent of patients with symptoms of abdominal pain, nausea, vomiting, and circulatory collapse. It may readily be overlooked in the comatose patient. Less frequently any of the other organ systems may be secondarily involved as complications.

TREATMENT

Chloramphenicol is unquestionably the drug of choice. Variations in dose and duration of therapy have been advocated. In our experience we have felt that maximum dosage and prolonged therapy is the most economical in the long run, particularly in prevention of relapse. It is our practice to give 70 to 75 mgms. per kilogram of body weight with half the calculated dose given at the beginning of therapy and then in four divided doses at 6 hour intervals. Thus, the average 70 kilogram patient would receive 2.5 grams immediately and 1 to 1.5 grams every 6 hours. This dose is maintained for two weeks and even if the patient appears completely recovered half this amount is given daily during the third week and then this same dose every other day during the fourth week. The average patient will become afebrile after the fourth day of therapy. Others prefer to discontinue the drug after two weeks and re-treat for 7 to 10 days if a relapse should occur. Since 5 to 30

per cent have relapsed during such a program we prefer the longer therapeutic regime.

Perhaps one may hesitate to use this drug over such a prolonged period in view of the occasional bone marrow toxicity that has been reported. However, it must be emphasized that this possibility has occurred on extremely rare occasions and usually in persons who have had an allergic background. By following the blood picture closely one can more readily avoid such possibilities. It is of interest to note that in our own unpublished observations monkeys receiving 250 mgm. of chloromycetin® per kilogram of body weight daily for one year have not shown any untoward reactions to date.

Despite the availability of a specific drug one must not neglect the importance of supportive measures. These should include absolute bed rest, good nursing care and oral hygiene. The diet should be carefully controlled with a high carbohydrate diet for its protein-sparing effect. Thus it should contain 60 to 80 calories per kilogram of body weight with 1 gm. of protein per kilogram of body weight with the rest predominantly carbohydrate. The diet should consist mostly of liquids or low-roughage solids. A typhoid patient can frequently be coaxed to eat, but if no adequate intake is maintained this way, a stomach tube may be used and supplemented with parenteral fluids. Vitamins, particularly B and C are invaluable, not only for supportive care but to prevent any of the untoward effects of prolonged broad-spectrum therapy.

Tepid sponge baths for high temperatures, hot abdominal stupes and rectal tubes for abdominal distention, and small low enemas on alternate days for constipation are of considerable value. Diarrhea may be corrected by scrutiny of the diet or by large doses of bismuth. Opiates should be used only as a last resort because of their contribution to distention.

PUBLIC HEALTH MEASURES

1. Isolate the patient and observe strict enteric precautions as well as strict fly control program. The excreta should be decontaminated with 10 per cent formalin or 5 per cent carbolic acid for 3 hours. Linens, bed-clothes and equipment should also be sterilized by boiling or autoclaving.

2. Report all cases promptly so that immediate control measures can be instituted.

3. Contacts should be particularly cautioned to observe care to avoid infection. It is good practice, however, to immunize household contacts as soon as the diagnosis is made. It is also of importance to secure rectal swabs on contacts to insure that they are not asymptomatic carriers.

4. After recovery the patient should have atleast three consecutive negative stool cultures before he mingles with society, and periodic cultures at approximately 3 month intervals. Clinical cure does not insure that the patient will not become a carrier. Should he become a carrier, specific arrangements should be made with the public health officer before discharge of patient.

5. Treatment of the carrier state still poses a considerable problem. Neither chloromycetin® nor any other drug is too effective. Since the majority (about 60 per cent) are gallbladder carriers, cholecystectomy may eradicate the state in this group.

PROPHYLAXIS

Although typhoid vaccine does not guarantee complete protection against infection it is of considerable value where the risk is high.

CONCLUSIONS

The purpose of this discourse is to serve as a periodic reminder that typhoid fever is still among us as a potential hazard. An average of six to eight patients are seen each year in University Hospital and many more around the state. If one retains a high index of suspicion, early recognition and control can be observed.

What Is the Effect of Diet On Atherosclerosis?

Definitely, diet is a factor in prevention and treatment of atherosclerosis. We have no control over the factors of sex and heredity—little control over the chance and local susceptibility that leads to death in one from a small critically placed lesion and allows another with extensive arterial disease to be clinically normal. Diet may be our chief hope of control. It seems unlikely that a syrup or pill can keep our arteries clean.

Results of experimental diets on human fat metabolism are somewhat contradictory. Total serum cholesterol appears to be fairly constant in a given individual and is little affected either by a single meal or by normal variations in cholesterol or fat intake. An egg or two a day makes little difference. Serum cholesterol levels are shifted up or down only by extremely high or unappetizingly low cholesterol and fat intakes.

The Sf 12-20 or Gofman fraction of serum cholesterol appears to be more sensitive to moderate reductions in diet and does decrease on ambulatory low fat diets. Further, the most recently emphasized fraction, the Sf 35-100, fluctuates promptly in relation to fat intake, is elevated during absorption of a fatty meal and in some individuals is also chronically elevated. This work on the Sf 35-100 supports the concept that atheroma might in part be the result of repeated fatty meal insults. Despite the finality of Gofman's conclusions regarding the importance of the Sf 12-100 particles in atherogenesis and the effects of diet and other factors on the concentration of these particles, many data remain to be accumulated and confirmed.—William Watts, M. D., and others, Seattle and Spokane, Wash.; *Northwest Med.*, 52:112, February, 1953.

Sickle Cell Anemia and Salmonella Osteomyelitis*

WILLIAM STANLEY SMITH, M. D.

THE present report is prompted by the finding of three established cases of osteomyelitis occurrying in conjunction with sickle cell anemia. The additional finding of Salmonella organisms as the causative agent in two of these cases, and a Salmonella-like organism in a third case posed a provocative problem in light of the high staphylococcal and streptococcal incidence in hematogenous osteomyelitis.

The Author

● Dr. Smith, Columbus, is a member of the attending staffs of University and Children's Hospitals; instructor, orthopedic surgery, The Ohio State University College of Medicine.

CASE REPORTS

Case 1. A nine year old colored girl entered the University of Michigan Hospital on January 23, 1947, with complaints of pain and swelling in the arms and legs. She also had a large draining sinus over the right arm, which was thought by her mother to result from a medication injection about two months previously.

For five years prior to admission, episodes of swellings of the extremities, fever, headaches, emesis, anorexia, weight loss, pallor, and jaundice were noted at two to three month intervals, but apparently with progressively closer regularity.

When first seen, there was mild emaciation and jaundice. There was a large indurated draining ulcer over the lateral aspect of the right arm. The spleen was mildly enlarged. The liver was palpable three centimeters below the costal margin. There was a loud systolic murmur best heard at the apex.

Significant laboratory findings included: Red blood cells 2,670,000; white blood cells 31,000; hemoglobin 9 grams; albumin-globulin ratio 0.8; total serum proteins 8.44 mg. per 100 ml. Sealed wet preparation of blood revealed pronounced sickling in 15 minutes. Cultures of drainage from the right arm, and later surgical exploration of the humerus revealed: "The culture submitted by you . . . is undoubtedly a Salmonella. Its biological characteristics are those of Salmonella . . .; however, the somatic antigens are too rough for typing . . . cultures remained rough and we are, therefore, unable to type it." The patient's serum agglutinated a stock preparation of paratyphoid B in dilutions of 1:5120.

Roentgenograms showed symmetrical involvement of both humeri and femora with marked thickening, sclerosis, and periosteal and endosteal bone proliferation. Numerous small sequestra and at least one cloaca were seen. The metaphysis was spared. The proximal third of the right ulna was also thickened and sclerotic.

Case 2.** † This was a six year old colored male whose illness began in October, 1945, with complaints of diarrhea, abdominal pain, and fever. Two weeks later he was given a blood transfusion because he was found to be anemic. Three weeks later, he was admitted to an army hospital in a semi-comatose, febrile condition. There a diagnosis of sickle cell anemia was established using a wet sealed preparation.

Blood transfusions were given on alternate days for two weeks. He was discharged against advice, but returned two weeks later with a history from his mother that he complained of pain in both legs and had been unable to walk. Purulent drainage from the right leg began spontaneously. He was admitted to Oliver General Hospital in February, 1946.

Examination revealed an emaciated boy who appeared ill. There was pain and swelling over both tibiae, femora, and proximal humeri. Movement of the shoulder was extremely painful. There was a loud blowing systolic murmur over the entire precordium. The liver and spleen were enlarged.

The diagnosis of sickle cell anemia was confirmed at Oliver General Hospital by wet sealed preparation. Initial culture of drainage from the right tibia revealed "paracolon organisms," later identified as Salmonella suipestifer and subsequent cultures taken at the time of surgery confirmed this finding. He later developed multiple spontaneous sinuses over both thighs and left forearm. X-rays revealed progressive destruction of the shafts of both tibiae, fibulae, femora, humeri, and both bones of forearms. Sequestration, involucrum, and cloaca formation were also present.

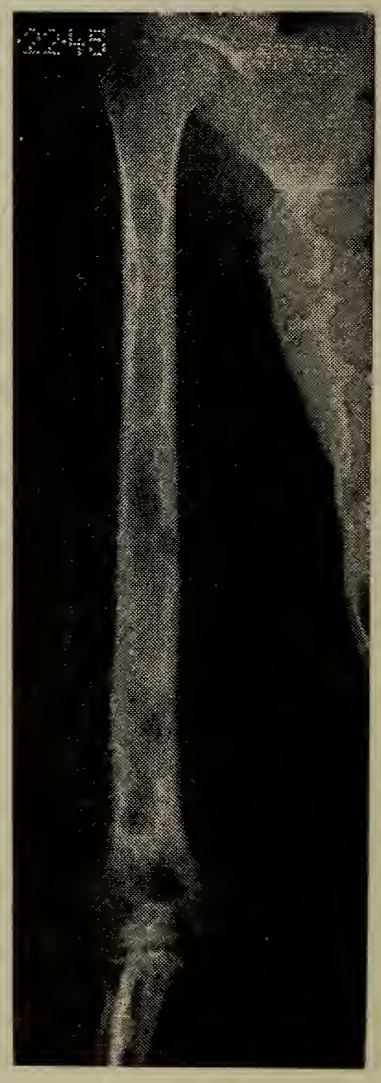


Fig. 3. Case 3.

Case 3. This was a twenty year old colored female who first noted pain and swelling of the right arm in 1943, associated with some fever and malaise. This regressed after one month and she had a similar episode in October, 1944. There was no draining sinus. One week prior to admission to the University of Michigan Hospital on October 7, 1945, she had a painful swelling of the right lower arm with stiffness of the elbow.

Examination showed

*From the Department of Surgery, Section of Orthopedic Surgery, University of Michigan School of Medicine, Ann Arbor, Michigan.

**Treated at Oliver General Hospital, Augusta, Georgia.

†Case of Lt. Col. Ernst Dehne, M. C., U. S. A., and the author.

an asthenic colored female appearing chronically ill. The abdomen was negative. There was a diffuse indurated swelling over the lower right arm. This was tender, but not warm.

Her temperature ranged between 99 and 101 degrees.

October 11, 1945, thirty centimeters of thick yellow pus were aspirated from the swelling of the right arm. Culture of this material revealed "a gram negative rod belonging to the paracolon group." Incision and drainage of the abscess was performed on October 19th and cultures again revealed a paracolon organism. Strains of paracolon organisms known to have caused disease have been shown to possess somatic antigens indentical with those of certain Salmonella. It was possible though not proven, that such was the case here.

Significant laboratory findings at this time were: Hemoglobin 8.0 grams per 100 cc.; white blood cells 14,500 with polymorphonuclear leukocytosis, an elevation of the platelets, sedimentation rated 18 mm. per hr. (corrected), and wet sealed red blood cell preparation revealed almost 100 per cent sickling.

Other operative work included a sequestrectomy and saucerization of the right humerus on November 27, 1945. Upon re-admission on April 29, 1947, another incision and drainage of a recurrent abscess in the same region was performed.

Pathology report after the first operation read as follows: "vascular pyogenic granulation tissue with young fibrous connective tissue. No evidence . . . of any other specific chronic infectious granuloma . . ." The decalcified bone showed "destruction of cancellous bone with fibrosis of the marrow spaces . . . active chronic osteomyelitis."

Roentgenograms of the humerus revealed cyst-like areas with rarefaction within the medullary cavity which were apparently expanding and widening the humeral shaft. There was extensive periosteal proliferation and several areas of bone destruction in the cortex. At that time, it was the opinion of Dr. J. F. Holt, associate professor of Roentgenology at the University of Michigan, that the x-ray picture was not typical of a non-specific osteomyelitis, but that a specific granulomatous lesion was suspected.

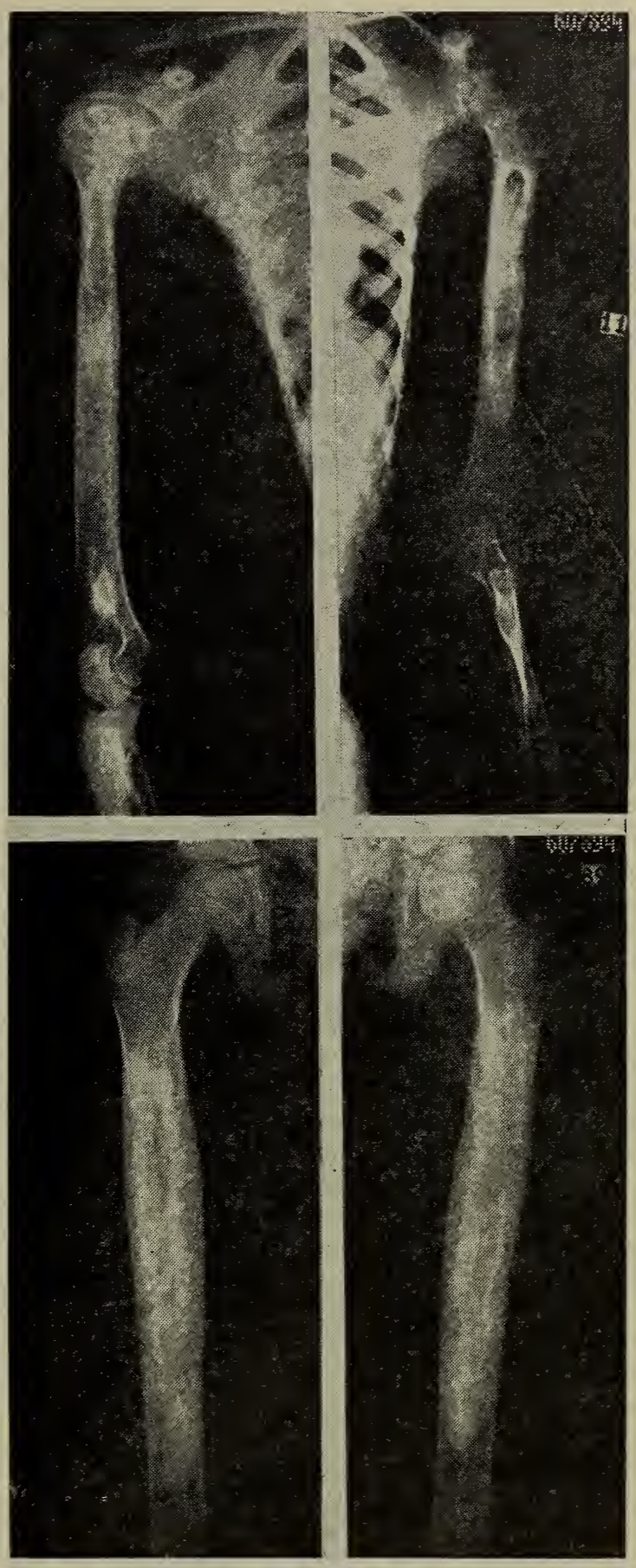


Fig. 1. Case 1.

COMMENT

In the absence of other complications, the bone changes in sickle cell anemia have long been well recognized.[3, 4, 5, 6] With the exception of isolated case reports, little attention has been given this condition when complicated by hematogenous osteomyelitis. There is no reason why a sickle cell anemia patient could not also have hematogenous osteomyelitis. In view of the well known susceptibility of such cases to infections, it would seem that the opportunity for bone infection would be proportionately enhanced.

Diggs, Pulliam and King[3] emphasize the fact that the roentgenographic appearance of bones of the majority of patients with sickle cell anemia is normal with respect to size, shape, and density. Only a few cases show the striking changes usually described.[3] Because these changes simulate inflammatory disease of bone, concomitant infection of bone is often overlooked or disregarded and the changes may be passed off as the result of the anemia. Furthermore, intercurrent infection is found to be the cause of death in some of the patients with sickle cell anemia, and localization of infection in bone has been reported.[3, 9, 10]

UNCOMPLICATED SICKLE CELL ANEMIA AND ITS BONE CHANGES

One of the most comprehensive reports of the bone changes in "uncomplicated" sickle cell anemia is the one of Diggs, et al.[3] The bone

marrow, usually hyperplastic, is characterized by both degenerative and reparative processes: thrombosis, infarction, necrosis, fibrosis, and new bone formation.[8]

Graham[12] in an extensive report on the first complete autopsy in such a patient, states that the changes represent the "end stages in a progressive osteosclerotic process." Summarizing the findings in his case, he states: "the picture is essentially that of a chronic infectious and toxic injury of the narrow tissue and medullary bone with subsequent repair processes and compensatory hyperplasia."

SALMONELLA INFECTIONS AND OSTEOMYELITIS

Localization of Salmonella infections in bone occurs with greater frequency than is generally known.[13, 14, 15, 16, 17] This is particularly true of Salmonella suipestifer. Gajzago and Gottche[15] reported that 17 of their 34 cases with Salmonella suipestifer infections developed osteomyelitis. Goulder, et al.,[16] and Harvey[17] reported a 20 per cent localization of Salmonella infections in bones or joints. On the other hand, Seligmann, et al.,[13] reported only two cases of osteomyelitis in 2,000 cases of Salmonella infections, 144 of which were Salmonella suipestifer. It is interesting to note that Harvey[17] also reported that of his 32 cases of Salmonella suipestifer infections, 27 occurred in negroes.

Salmonella infections are manifested either by enteritis and bloody diarrhea or somewhat less commonly by localized processes due to contact or hematogenous spread to the lungs, bones, meninges and other locations.[13, 14, 15, 16, 17] Individuals living under poor hygienic and economic conditions[15] or populations already weakened by starvation and exposure,[16] fall easy prey to Salmonella infections. Older people with chronic diseases such as diabetes, arteriosclerosis, etc., are susceptible to Salmonella infections.[13]

Of further interest is the autopsy finding of small infarcts in the spleen, lungs, and brain.[3, 5, 6, 8]

Roentgenologically, the majority of cases are negative from the standpoint of the osseous system. The principal findings in the cases where bone changes are found are those of osteosclerosis with cortical thickening of the shafts of long bones. There may be evidence of new bone formation within the medullary cavity. Longitudinal lines of decreased density in the shafts of long bones have been described. In the prominent case with osseous involvement, the trabeculations are conspicuously parallel to the shaft of the long bones, but there may be perpendicular striations from the cortex in rare cases. The changes in their advanced form are not unlike those of chronic inflammatory disease.

In the unusual case, the skull findings described are an increase in thickness, absence of a well defined outer table, osteoporosis, and perpendicular radiating trabeculations. Loss of vertical height of the vertebral bodies has also been reported.

DISCUSSION

The finding of Salmonella osteomyelitis in two cases and a Salmonella-like organism in a third case with sickle cell anemia suggests more than a casual relationship between the two conditions. Three other instances of this combination have been reported.[3, 9, 10] Two additional cases, verified bacteriologically, operatively, and pathologically, were observed by Dr. Wolf W. Zuelzer.[11]

Certain facts must be reckoned with when considering this peculiar combination of two diseases. With respect to sickle cell anemia, the bone changes have already been referred to. Additionally, the finding of multiple small infarcts in other organs is worthy of note.

Bauer[8] has summarized the essential pathologic process in sickle cell anemia as "stagnation and conglutination of disfigured red blood corpuscles." He states that the consequences are thrombosis, ischemia, necrosis, and fibrosis. The changes in bone subsequent to interruption of circulation have been well described by Phemister.[18, 19] When we consider the reparative process attendant with necrosis of bone, as described by Phemister, then the bone changes in sickle cell anemia are more clearly understood. Fundamentally, the similarity of the processes of thrombosis and infarction in both sickle cell anemia and acute hematogenous osteomyelitis is noteworthy. In some cases of sickle cell anemia, it is likely that the stage is already set for the pathogenesis of hematogenous osteomyelitis.

The comments on Salmonella infections already mentioned need little elaboration. The high incidence of Salmonella infections in persons living under poor hygienic and economic conditions, as well as the tendency to develop in the chronically ill, is significant. We have also noted the propensity of Salmonella infections to localize in organs other than the gastrointestinal tract and the frequency of involvement of bone with certain Salmonella infections.

The differentiation between septic infection occurring on the basis of sickle cell anemia alone and bacterial osteomyelitis deserves special mention. This is a troublesome problem, both from the clinical and radiologic standpoint. Septicemia and bone pain in a patient with sickle cell anemia may mean either localization of infection in bone, sterile infarcts on the basis of the blood disorder, or both. Bacteriological cultures from the blood, aspirated material from fluctuant areas of the extremities, and specific agglutination studies will all be helpful.

Radiologic interpretation alone cannot be relied upon in this subtle differentation. Furthermore, adequate specific antibiotic therapy in such cases may subsequently mask the diagnosis of bacterial

osteomyelitis. Conceivably such cases may never be proven except in the event of specific agglutination reaction or acute exacerbation.

SUMMARY

1. Two cases of Salmonella osteomyelitis and one of a Salmonella-like osteomyelitis occurring in three cases of sickle cell anemia are reported. At least five other instances of this combination have been noted elsewhere.

2. The similarity of the bone lesions of sickle cell anemia and the early lesions of acute hematogenous osteomyelitis is noted.

3. The roentgenologic picture of cases of sickle cell anemia with bone changes probably represent the changes due to infarction and its response.

4. An attempt has been made to correlate known facts about sickle cell anemia and Salmonella osteomyelitis and their relationship to each other.

5. The difficulty in differentiating between a septic infection occurring on the basis of sickle cell anemia alone and bacterial osteomyelitis is noted.

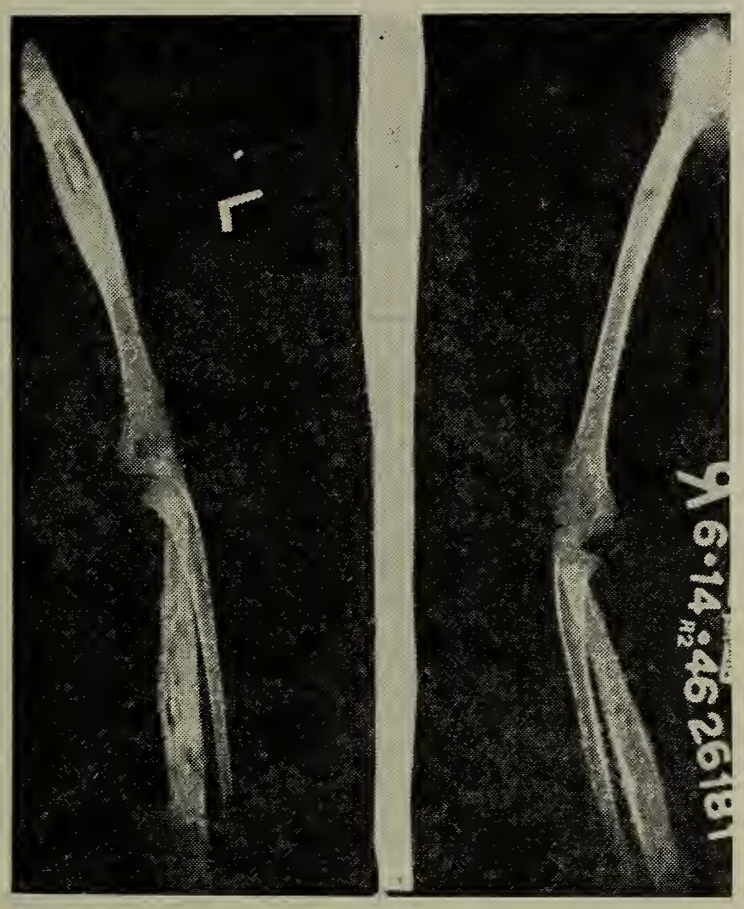


Fig. 2. Case 2.

Acknowledgment: The author is indebted to Dr. Wolf W. Zuelzer, Pathologist to Children's Hospital of Michigan, Detroit, and to Dr. Warren K. Wheeler, Children's Hospital, Columbus, Ohio, for their helpful suggestions and criticisms in the preparation of this paper.

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Hereditary Cephalalgia

The degree of relief of heredity cephalalgia has been evaluated after the use of four drugs (ergotamine tartrate, caffeine, bellafoline substance and pentobarbital sodium) administered either singly or in various combinations, by subcutaneous, oral and rectal routes, with the following results:

1. Ergotamine tartrate (Gynergen), subcutaneously, is the most effective of these four drugs in relieving an attack of hereditary cephalalgia.

2. E. C. B. P. 163 (ergotamine tartrate 2 mgs., caffeine 100 mgs., bellafoline substance 0.25 mgs. and pentobarbital sodium 60 mgs.) in suppositories, is almost as effective as ergotamine tartrate, subcutaneously, and has the advantage of easy administration.

3. Cafergot, orally, and E. C. 112 (ergotamine tartrate 2 mgs. and caffeine 100 mgs.) rectally, have almost the same degree of effectiveness, showing that oral and rectal routes are equally efficacious, with the latter having the advantage in cases of nausea and vomiting.

4. The combination of ergotamine tartrate with pentobarbital sodium, rectally, is more effective than E. C. 112, but not as effective as E.C.B.P. 163.—Cecil M. Charles, M. D., St. Louis; *Missouri Med.*, 50:186, March, 1953.

Use of the Cerebrospinal Fluid System As an Accessory Kidney

Preliminary Note and Report of a Case

WILLIAM R. CHAMBERS, M. D.

KIDNEY shutdown, particularly in the presence of some of the severe complications of generalized vascular disease, and concomitant with major surgery, may be a real hazard to life. According to Hardy,[1] "a temporary increase in adrenocortical function in response to operative trauma plays a significant role in the postoperative retention of salt and water."

To rid the body of this excess salt and water until the kidneys can recover may be life saving. Seligman, Frank, and Fine[2] quote Gamble, "The defense of the chemical structure of extracellular fluid is of much more importance from the point of view of survival than reduction of azotemia." Many elaborate devices have been developed to remove the excess electrolyte. These authors[2] discuss the irrigation of the peritoneum with Tyrode's solution. The use of the artificial kidney is well known, but requires special materials and trained personnel.[3] Such methods are difficult in the small hospital in these days of nursing shortage.

A readily available method of removing salt and water, and preferentially sodium chloride and water, requiring minimal personnel and the simplest of apparatus would provide a more practical tool in the small hospital in the small community. The cerebrospinal fluid, besides water, contains a greater concentration of sodium chloride than the blood plasma (440 mg. per 100 cc. as compared to 360 mg.) and a lower concentration of potassium (14.7 mg. per 100 cc. as compared to 22 mg.)[4] It is also available in considerable quantity. According to Best and Taylor[5] "When artificial drainage is provided . . . several liters per day may drain away." Furthermore, the cerebrospinal fluid pressure, and presumably the volume, goes up in the presence of anuria. Should only two liters be drained off per day, a loss of 8.8 grams of sodium chloride might occur.

That there is an appreciable salt loss, even without renal block, is attested to by the work of Matson[6] who mentions the importance of adding salt to the diet of all infants who have had a ventriculo-ureterostomy for hydrocephalus. Since water is retained to the extent of one liter for every 6 or 7 grams of sodium chloride,[7] removal of 8.8 grams may represent a considerable volume of water available for excretion by the kidneys. According to Marriott[7] "the kidneys will not, save in exceptional circumstances, retain water in the absence of salt."

Submitted September 19, 1952.

The Author

● Dr. Chambers, Cincinnati, is a member of the staff of Good Samaritan Hospital.

It was with these observations in mind that continuous spinal drainage, by means of the same technique as is commonly used for continuous spinal anesthesia, was instituted. It was not possible to do the tests and estimations desirable to establish the efficacy of the method. The case is offered rather as a suggestion for therapy, to be followed up at better equipped institutions.

CASE REPORT

History: The patient, a 54 year old white, male, a known hypertensive, suffered a sudden severe pain in the head, and vomited, while in the bath. His wife found him helpless in the tub. His left face, arm, and leg were paralyzed.

On examination he was conscious and oriented. The pupils were equal in size and reacted to light. His voice was husky, there was some mucus in the throat. The pulse was 58, blood pressure 160/72, respirations 20. The deep tendon reflexes were approximately equal on the two sides, but a Babinski was present on the left. The fundi were not adequately visualized.

During the ensuing six days, the patient's course was slowly but steadily down hill. Spinal tap showed xanthochromic fluid; the pressure was not taken. On the sixth day the patient was comatose, and the blood pressure, which was usually in the neighborhood of 200 systolic was 110/70. The pulse was 90, respirations 22, and the rectal temperature 101[2] degrees.

Hospital Admission: He was admitted to the hospital on May 20, 1950. Neurosurgical consultation was called, and a ventriculogram was made which showed a mass in the right parietal area. This area was explored and a large blood clot encountered at considerable depth. This was washed out as well as could be done through large ventricular needles. The procedure was a minimal one, as a laboratory report was returned, during the operation, that the blood urea was 132 mg. per 100 cc. It was then also learned that the patient had passed no urine since admission, almost 24 hours previously.

According to the work of Matson,[8] on the surgical treatment of hydrocephalus, one of the

precautions to be taken, when the cerebrospinal fluid system is connected to the ureter, is the addition of salt to the diet to compensate for the loss of sodium chloride by way of the excreted spinal fluid. Reasoning backward, it was felt that salt retained in the body due to renal shutdown could be decreased by spinal fluid drainage.

Procedure: Accordingly, when next day the patient appeared unimproved, and the renal block still existed, a polythene tube was inserted and allowed to drain continuously into sterile dressings. Soon it was felt that the patient's condition was improving. He voided twice. He was perspiring profusely.

The spinal catheter was removed approximately 24 hours after its insertion, and again the patient ceased to secrete urine, his state of consciousness became cloudier, and his respirations irregular. His blood urea rose to 200. Rapidly the respirations assumed a Cheyne-Stokes rhythm.

The spinal catheter was again inserted, and the patient's general condition improved. At intervals thereafter, the spinal drainage was clamped off, but each time he became worse, and when it was resumed, he became better.

On May 25, 1950, just before spinal drainage was made continuous, his blood urea was 208 mg. per 100 cc. and his blood creatinine 3.3 mg. per 100 cc. On May 29th, his creatinine was 3.7 mg. and his CO_2 combining power was 68 volume per cent.

On June 3, 1950, the creatinine was 2 mg. per 100 cc., and on June 16th, 1.6 mg. The spinal drainage was then discontinued. The urine output was now satisfactory.

Follow-up: The patient has continued to make a slow, but steady recovery and more than a year later, has started to walk without help.

DISCUSSION

While it cannot be proved, without further data, that the draining off of the spinal fluid was sufficient to break the renal block. the fact that the patient improved each time drainage was instituted, and deteriorated each time it was shut off, was of some significance. If additional cases could be tested for total fluid, sodium chloride, and potassium lost from the body, a valuable weapon against anuria might be found in this method.

It should lend itself to excellent regulation, for the amount of water and salt lost should be subject to control simply by clamping the polythene tube, while the absolute amounts of various electrolytes could be measured, and those lost in excess of what might be desirable could be returned to the body by intravenous injection. The method has the principal advantage of being available anywhere, with a minimum of materials and personnel.

SUMMARY AND CONCLUSIONS

A suggestion is made for the removal of water and salt from the body, in renal shutdown, by continuous drainage of spinal fluid. This method has the advantage of being readily available even in small communities, where limited personnel and equipment would make other methods impractical. A case is presented in which this method appeared to be of benefit.

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Trichinosis in Man—Its Prevention

An account is given of the history of trichinosis, its life cycle, and the principal clinical features of the disease in man, including the symptomatology, diagnosis and treatment. Although in autopsy surveys of over 10,000 persons in the United States, the average incidence of recovery of trichina larvae is 16 per cent, it has been found that if the methods of examination are more thorough, the incidence is about 30 per cent.

Available data indicate that the incidence of trichinosis both in man and in swine in the United States is the highest of any country in the world. While the vast majority of human infections are mild and subclinical, most infections that are severe enough to reach the clinical level are not diagnosed, and among those that are clinically diagnosed, the mortality rate is about 5 per cent.

Besides thorough cooking, the methods of prevention include curing and low-temperature treatment as prescribed by Federal regulations. Other control measures adopted by some countries are microscopic inspection of muscle from every hog that is slaughtered, prevention of feeding of garbage to hogs or cooking of raw garbage if it is to be fed to hogs.

Promising new methods of rendering pork free from the danger of trichinosis include (1) extension of technics for low-temperature treatment and (2) exposure of all raw pork to ionizing radiation. These latter methods should be subjected to further intensive research. High hope is held that in the near future all raw pork may be so processed as to reduce the danger of trichinosis to man to a point of practical insignificance in this country.—S. E. Gould, M. D., pathologist, Wayne County General Hospital, Eloise, Mich., and clinical professor of pathology, Wayne University College of Medicine, Detroit, Michigan.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

Cord Under Ligament Herniorrhaphy*

C. R. LULENSKI, M.D.

ALTHOUGH the science of surgery has widened to entail elaborate diagnostic measures and physiological preoperative and postoperative care, a basic responsibility of all surgeons continues to be the performance of technically perfect operative procedures. In this respect the aim of all inguinal hernia repairs is the establishment of a strong and anatomically sound groin wall. Particular reinforcement should be developed at the hernial site and at all places of present or future weakness.

As in most operations, the first performance carries the greatest likelihood of permanent success. This report deals with the therapy of the previously unoperated inguinal hernia. This problem is of great importance because nearly 10 per cent of males show evidence of this pathology at some time during the life span. Surgery of groin ruptures has wide application because it is performed frequently and by many thousands of surgeons over the world. Only 1 per cent of females are affected with this development and therefore cure in the male is the primary concern.

The operations proposed have varied from simple narrowing of the internal ring to elaborate replacement of most of the inguinal wall by the introduction of a foreign substance such as tantalum mesh. Certainly over 95 per cent of the unoperated inguinal hernias can be repaired without the addition of fascia or other material foreign to the groin.

That improvements along this line are necessary is readily apparent from the fact that the usual recurrence rate is 7 per cent or more.[1, 6] Most of the failures occur among patients in the older age groups who had large direct hernias. The reports do not stipulate the incidence of femoral ruptures in the follow-up studies. Prevention of this should be an integral part of proper herniorrhaphy.

Unfortunately the technical work in hernia repair is considered simple and unimportant. The actual operation is all too freely and frequently relegated to the assistant without close supervision.

REGIONS SUSCEPTIBLE TO HERNIA

In studying this problem, it is apparent that there are two susceptible regions in the inguinal wall that pertain particularly to hernias. These are the conjoined tendon area and the internal and external rings. In the primary herniorrhaphy there is almost always sufficient and adequate tissue for repair. This situation is the one most deserving of consideration. The emphasis thus far has been on strengthening of the conjoined tendon weakness and this has been attained by the Cooper's ligament type of hernioplasty as adequately described by McVay and Anson[7] and Burton.[2] This also helps prevent a later femoral hernia.

No similar adequate correction has been propounded for the internal and external rings region. The most complete solution is to remove the canal and rings entirely. The canal is obliterated in present-day methods by placing the cord subcutaneously and by putting the external ring immediately anterior to the internal. This has improved results but complications occur to the extent of 5 to 10 per cent referable to swelling of the cord and/or the testis due to tight closure at the rings. On the other hand, if the rings are made too large the incidence of recurrence increases disproportionately.

It seems logical that if one could remove the rings completely, a more secure wall should be possible. This was suggested by Cheever[3] in 1923. He withdrew the testis from the scrotum and placed it through the femoral canal beneath Poupart's ligament and then returned it into the scrotum. For reasons unknown this new idea was not accepted. Perhaps a later high incidence of femoral hernia was a great drawback. There was no other mention of this type of procedure until MacFee[5] in 1940 and Heffez[4] in 1951 reported cases.

The method used consisted of transecting the inguinal ligament, allowing the cord to recede posteriorly onto the pectineus fascia to enter the femoral canal and then reforming the inguinal ligament. This may prove difficult or impossible at times and in such instances a large hernia may develop. Even though the ligament is reformed, the transection and attendant constriction and trauma of suturing will frequently result in a much attenuated structure.

NEW PROCEDURE DEVISED

To obviate the complications from the presence of the inguinal rings and to prevent the difficulties encountered from the procedures advocated by Cheever,[3] MacFee,[5] and Heffez,[4] the author has devised a new operative technique

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Submitted February 17, 1953.

which is particularly suited to the older age group with the large direct and/or indirect hernias. In these individuals all the structures are frequently weak and thin. Orchidectomy to facilitate and improve the usual herniorrhaphy in such a case is advised but almost always rejected by the patient. This is an additional reason for having this "cord under ligament" operation as part of the armamentarium so that the best operation may be done for the circumstances at hand. It must be emphasized that in the large hernias in the older age group the transversalis fascia (so much described as being all important in the repair) is very much attenuated or absent.

TECHNIQUE OF OPERATION

The operation is begun by the usual incision from over the pubic spine laterally for 3½ to 4½ inches parallel to, and ½ to ¾ of an inch superior to the line of the inguinal ligament. The incision is deepened to expose the external oblique aponeurosis. All transected vessels are ligated with 0000 silk. The exposed aponeurosis is divided along its fibers beginning at the mid lateral aspect of the external ring. Superior and inferior flaps are developed and the cord and sac (if present) are elevated from the canal floor.

If the hernial sac is shallow and direct, it is reduced without opening it. If it is indirect or long and direct, it is dissected to its peritoneal mouth at which level it is suture-ligated with 000 silk. The superfluous portion is amputated and the transfixed stump is transplanted for ¾ to 1½ inches superiorly beneath the aponeurotic internal oblique-transversalis layer. The testis is next withdrawn from the scrotum and the gubernaculum is transected.

The transversalis fascia and the fascia lata posterior to the inguinal ligament and lateral to the femoral vessels in the lacuna musculorum are incised horizontally for 1 to 1½ inches. The inguinal ligament is elevated at this place and the testis is displaced beneath it and into the thigh. From there the testis is taken through the subcutaneous space of the thigh and is returned into the scrotum. It is held in the proper position by repairing the divided gubernaculum by interrupted 000 silk. Thus, the new route of the testis is retroperitoneal until the subcutaneous region of the thigh is reached. As a result there is no longer any inguinal canal nor inguinal rings to contend with in the repair.

METHOD OF CLOSURE

Two or more sutures of 00 silk are used between the inferior edge of the inguinal ligament and the incised fascia lata and transversalis fascia medial and lateral to the cord under the ligament. The sutures are so placed that the final opening in the lacuna musculorum is just sufficiently large to allow the cord to pass without being compressed. This procedure thus stabilizes the cord laterally and separate from the femoral canal and therefore there should be no increased incidence of femoral hernia. No further manipulation of the cord is necessary and this should reduce the total amount of trauma that the cord is ordinarily subject to during the usual herniorrhaphy.

The remainder of the repair is attained by Cooper's ligament technique with the most medial suture of 00 silk attaching the lateral inferior edge of the rectus sheath to the fascia over the pubic tubercle. From this point outward the inferior edge of the aponeurotic part of the internal oblique and transversalis layer along with plications of the transversalis fascia (if present) is apposed to the iliopectineal ligament by interrupted 00 silk until the medial edge of the femoral vein is reached.

In obese patients it is best to apply the most lateral suture first and continue medially to pubic spine. It is wise to use the lateral inferior edge of the rectus sheath if the conjoined tendon is lacking in strong fascia. Apposition to Cooper's ligament is of great help because in most large direct hernias there is little or no transversalis fascia and by use of the above maneuver a firm base is formed. Furthermore, using Cooper's ligament in the repair reduces the later incidence of direct hernias and of femoral hernias.

Superior to the femoral vessels and laterally the internal oblique-transversalis layer is sutured to the shelving part of the inguinal ligament. The operation is continued by applying the inferior edge of the superior external oblique aponeurotic flap to the same line by interrupted 000 silk. This is covered by overlapping with the inferior external oblique flap. The subcutaneous fat and fascia are closed over the cord by interrupted 0000 silk and the skin is closed by clips.

SUMMARY OF REPAIR

By the above method the two places of weakness are corrected. Likewise by careful dissection less than the usual trauma is inflicted on the spermatic cord. This procedure differs from that described by Cheever, MacFee and Heffez in that the femoral canal has no additional tissue in it and in that the inguinal ligament is not transected. To the author's knowledge this type of repair has not been performed previously. This method may be particularly applicable in the older age group in which the entire testis is mobilized as in an associated hydrocele and in those cases in which orchidectomy is recommended to accomplish a better herniorrhaphy. By employing the technique described the same result is obtained without sacrificing the testis.

In the younger age groups and in those with good structures the cord under ligament transplantation need not be done because by use

of the Cooper's ligament repair method a sufficiently firm inguinal wall can be fashioned. That is, the cord is passed through new internal and external rings and is otherwise subcutaneous.

STATISTICS

Eleven patients have been operated upon by the cord under ligament method. The first patient was repaired almost two years ago. All of the patients were males with ages varying from 9 to 64 years. The immediate postoperative course was uneventful excepting for edema of the testis in two instances, a subcutaneous wound infection in one patient and a prolonged postoperative ileus in another. The last mentioned was the first patient operated upon and it is believed that due to an oversight the fascia lata was not sutured snugly on the lateral aspect of the opening through which the cord was passed. All other patients had 00 silk sutures placed to each side of the transplanted cord to prevent later widening or rupture of the fascial opening.

Examination at 15 months to 2 years after surgery reveals good union in all except the first patient. That 64 year old white male, with markedly attenuated structures, developed a recurrence beneath the inguinal ligament at 4 months postoperatively. In each of two patients the testis is about ¾ inch higher in the scrotum than it was postoperatively. However, there is no symptom referable to this. Excepting for the before mentioned first patient, all patients reveal a firm inguinal wall and have no complaint.

Operative and postoperative difficulty with the testis was for the most part relegated to the four patients below age 35. Apparently the cremasteric muscle and the cord structures are shorter and less elastic in the younger age group. This may be a contraindication to this operation for those below age of 35. In the older age group with elongated structures this operation is technically only slightly more difficult than the usual herniorrhaphy.

A longer survey is necessary to determine the value and width of application that this procedure may have. It should be considered as an addition to our armamentarium used for the surgical correction of inguinal hernia in the male.

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KEEPING UP WITH MEDICINE

• A BETTER UNDERSTANDING of the disturbed physiology of the various myopathies leads to a more intelligent method of treatment.

* * *

• IN THE MANAGEMENT of acute poliomyelitis the advisability of using sulfonamide, penicillin, or other antibiotic—preferably by the oral route—in controlling pulmonary infections in the presence of bulbar or respiratory paralysis need only to be called to mind.

* * *

• ESTROGENS of all types are specifically contraindicated in the presence of a breast tumor or in a patient with a family history of cancer of the breast, in the presence of a cancer of the uterus, or in the presence of a menorrhagia occuring in the menopausal years.

* * *

• IN SENSITIVE individuals the intramuscular injection of thiamine may be followed by nausea, sneezing, vasodilation, urticaria, cyanosis, and death; or on the other hand by a sloughing of the injection site.

* * *

• DERIVATIVES of belladonna should never be used to control cough or to diminish bronchial secretion.

* * *

• THE ADMINISTRATION of 1 microgram daily of vitamin B_{12} has been found to produce a satisfactory response in practically all cases of pernicious anemia. In practice, however, there is no need to give minimal doses.

* * *

• IN GENERAL, it can be stated, that vitamin B_{12}, folic acid, and liver extracts have no beneficial effects in iron deficient anemias.

* * *

• FOR THE PATIENT with a chronic nephrotic syndrome, 1.0 gram of protein per kilogram of body weight seems to be the optimal amount to take.

* * *

• AS IN ARSENIC poisoning, so in mercury poisoning, the treatment has been revolutionized by the introduction of BAL.

* * *

• ONE OF THE most serious complications in the use of tridione® in epilepsy is the depression of the bone marrow and another more annoying but not so serious is the photophobia on exposure to sunlight.

* * *

• STRANGELY ENOUGH a 40 per cent sulphur formula for treatment of acne rosacea is less apt to irritate than a 5 per cent concentration.

* * *

• IN THE TREATMENT of rheumatic fever, salicylates are the only drugs which have survived the test of time.—J.F.

The Use of Nupercaine® for Spinal Anesthesia

EDWARD B. DEPP, M. D.

NUPERCAINE® is a fascinating drug, fascinating from the standpoint that it will provide 3 to 4 hours of excellent anesthesia when administered into the subarachnoid space. This duration is considerably in excess of any of the other commonly available local anesthetic drugs; for example, procaine will last 3/4 to 1 hour and pontocaine® will last 1½ to 2 hours.

This report concerns the use of nupercaine® for spinal anesthesia personally administered by the author in 1000 cases over a period of six years. The patients ranged in age from 11 to 94 years. Approximately 40 per cent of the patients were male, 60 per cent female, although there was no selection here, this being in proportion to my total practice. All of the patients received preanesthetic medication.

SITE OF OPERATION

The site of operation was classified as follows: Perineal operations, including hemorrhoidectomy, cystoscopy, transurethral prostatectomy, vaginal delivery and all operations where a low level of anesthesia will suffice; operations on the extremities and extraperitoneal regions where a medium level of anesthesia is adequate, including inguinal and femoral herniorrhaphy, laminectomy, orthopedic procedures, pilonidal sinusotomy, suprapubic prostatectomy, skin graft; and intraperitoneal operations where a high level of anesthesia is required. The intraperitoneal group was not subdivided into upper and lower abdominal operations because it has been my observation that when traction is made on any of the viscera, notably the stomach, gallbladder, uterus and appendix, painful traction reflexes occur unless the level of anesthesia is between T-4 and T-6. This corresponds to the top levels of the splanchnic nerves, which may carry sensory impulses. The number of cases in each group was as follows: perineal 29, lower extremities and extraperitoneal 88, and intraperitoneal 883.

AGENTS AND DOSAGE

Nupercaine® was used in three different solutions, a "home-made" solution made up fresh each morning with a specific gravity of 1.002, commercial Howard Jones' solution[1] with a specific gravity of 1.004 and commercial 1/4 per cent nupercaine® in 5 per cent dextrose solution with a specific gravity of 1.017. The specific gravity of cerebrospinal fluid varies from 1.002 to 1.009, averaging 1.006. It is customary to administer spinal anesthetic drugs in solutions distinctly lighter (hypobaric) or distinctly heavier (hyperbaric) than the spinal fluid, since it is not practical to measure the specific gravity in each patient. Then the direction of flow of the solution is definite, and by variations in position of the patient this property can be used to regulate the desired level of anesthesia.

The "home-made" solution was used in 464 cases and contained 2 mg. of nupercaine® per cc. in distilled water, to which varying amounts of epinephrine were added. The concentration of epinephrine was varied from 1:20,000 to 1:833. No consistent difference in anesthesia was observed in this group of cases, regardless of whether epinephrine was present or absent. Since the presence of a vasoconstrictor did not appear to influence the duration or intensity of spinal anesthesia, it was omitted in all subsequent patients. The dose of this solution was 1 to 6 mg. (0.5 to 3 cc.), depending on the site of operation.

Howard Jones' solution is nupercaine® 1:1500 in 0.5 per cent saline and is provided by the manufacturer in 20 cc. ampules, containing 13⅓ mg. of the drug. This is a rather cumbersome volume and requires a large syringe for administration. It was administered in 174 cases, the dose used being 4 to 13⅓ mg. (6 to 20 cc.).

Nupercaine® 1/4 per cent in 5 per cent dextrose solution is supplied in 2 cc. ampules, containing 5 mg. of the drug. It is considerably more expensive than the other commonly used spinal anesthetic drugs, and two or three ampules must be opened if more than 5 mg. is needed for one patient. It was administered in 362 cases. A dosage schedule of 5-10-15 mg. (2 to 6 cc.) of this solution was used, similar to that reported by the author for pontocaine.®[2]

Five milligrams of nupercaine® were given for perineal operations, 10 mg. for operations on the lower extremities or extraperitoneal region and 15 mg. for intraperitoneal operations. Cesarean section is an exception, where 6 to 8 mg. is sufficient. This dosage schedule was increased or decreased a milligram or two, depending on the circumstances in each individual case. The maximum dose was 15 mg., which was rarely necessary. The duration of anesthesia is a

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Submitted March 6, 1953.

physiological property of the drug itself and is little influenced by the dose.

All of these solutions are perfectly satisfactory for spinal anesthesia, provided adequate doses of the drug are given.

INDICATIONS

As with all anesthetic agents and methods, the skill of administration is considerably more important than the use of a particular agent or method in spinal anesthesia. With increasing experience, the indications become more relative than absolute. Table 1 shows that most of my use of nupercaine® was for intraperitoneal operations. The main field of usefulness of nupercaine® is for operations expected to last over 2 hours, especially where profound muscular relaxation is essential. No other agent or method of anesthesia will regularly provide relaxation comparable to spinal anesthesia, and no surgeon who once becomes accustomed to this type of relaxation will be satisfied with less.

Age in itself is no contraindication to spinal anesthesia, provided lumbar puncture can be easily performed. Spinal anesthesia was reserved for good and fair risk patients and no patient in this series was considered to be a poor risk. Other advantages of spinal anesthesia in general are where it is necessary to have the patient awake for one reason or another, maximum postoperative comfort and cooperation of the patient are provided and the explosion hazard is absent.

Contraindications are: an aversion to the method on the part of the patient or surgeon (this is always respected, regardless of whether the aversion is real or imaginary; it is more important to me to get along with the patient and surgeon than to give a particular anesthetic), the presence of neurological disease, the presence of gross obesity or deformity of the spinal column making atraumatic puncture impossible, and skin infection at the contemplated site of puncture. A previous lumbar puncture headache was not always considered a contraindication; each case must be studied individually.

USUAL TECHNIQUE

Lumbar puncture can be performed with the patient in either the sitting or lateral position; it is technically easier in the sitting position. If a hypobaric solution is being used, puncture is made in the sitting position and the patient kept that way for 1 to 2 minutes, if a high level is desired; if a lower level is satisfactory, the patient is returned immediately to the level position. If a hyperbaric solution is being used, puncture is made in the lateral position and the patient tipped 10 degrees, head down for a high level, head up for a low level, and kept flat for an intermediate level of anesthesia.

The patient is placed in position and the skin prepared and draped in the manner of choice of the operator. A skin wheal is raised at the site of injection with 50 mg. of ephedrine in 1 per cent procaine solution and the excess injected into the erector muscles. The site may be any suitable interspace in the region of a line drawn between the crests of the ilia, usually between L-3 and L-4. A Pitkin needle director is inserted through the wheal and posterior spinous ligament. A 3 inch 20G spinal needle is then inserted into the subarachnoid space, through the director. When a free flow of cerebrospinal fluid is obtained, the required dose of nupercaine® is injected and the patient returned to the desired position. Anesthesia is complete in 15 to 25 minutes; painful procedures should be delayed until sensation is abolished.

The chief factors in obtaining satisfactory levels of spinal anesthesia are: the dose of drug, specific gravity of the solution and the position of the patient. Other factors, which did not appear to be significant in this study, are: volume of injected solution, rate of injection, site of injection, and a directional needle.

SUPPLEMENTATION

No supplementary anesthesia was used in 46 cases. It was considered desirable or necessary to supplement the spinal anesthesia in 954 cases, or 95 per cent. For supplementation cyclopropane, nitrous oxide, ethyl ether, vinethene® and pentothal® were used, alone or in combination, depending on the circumstances, mainly to obtain the advantages of balanced anesthesia. In no instance in this series was a case started under spinal anesthesia alone and then supplementary anesthesia found necessary for any reason.

On the other hand, spinal anesthesia with nupercaine® was considered inadequate in height or duration in 45 cases, or 4.5 per cent. A similar number of cases will occur regardless of the drug used. Inadequate height was judged to be present when troublesome traction reflexes occurred or the relaxation was not satisfactory to the surgeon. A certain inaccuracy is necessarily present here, since the inadequacy has to be judged in a patient who is receiving some form of supplementary anesthesia that might mask the signs.

COMPLICATIONS

The chief complication of spinal anesthesia was hypotension. Hypotension was arbitrarily defined as a fall of more than 20 mm. in systolic blood pressure over the preanesthetic level during the first hour of anesthesia. Hypotension that occurred later than this was not considered to be due to spinal anesthesia. Hypotension occurred in 19 per cent of the cases in which nupercaine® was used. In a parallel series of similar cases, using pontocaine® for spinal anesthesia, the incidence of hypotension was 18 per

cent. The incidence of hypotension is not related to the drug used but to the number of spinal segments blocked, and hence the number of vasomotor fibers blocked. Hypotension certainly occurs much more frequently with high levels than with low levels of anesthesia. In every case where hypotension occurred it responded readily to prompt treatment. The blood pressure never fell to zero in any patient. Hypotension, therefore, was not a source of serious concern.

Lumbar puncture headache is a complication regardless of the drug used for spinal anesthesia or if no anesthetic is given. It is thought to be purely mechanical, due to the lowering of the pressure, with loss of cerebrospinal fluid causing traction on the sensitive structures of the brain. When the needle tract heals and the spinal fluid pressure returns to normal, the headache disappears. In favor of this theory is the fact that the use of smaller needles is accompanied by a reduction in the incidence of headache, and the use of a needle that will not cut the dural fibers, such as the Whitacre needle,[3] is accompanied by a further reduction.

In a group of 652 unselected cases out of the entire nupercaine® series, comprising 266 males and 386 females, the incidence of lumbar puncture headache varied considerably. All these patients were interviewed carefully by the author. Among the males there were 6 headaches, or 2.3 per cent, and among the females 25 headaches, or 6.5 per cent. I can offer no explanation for this difference. Following the use of a 20G needle in 153 cases there were 13 headaches, or 8.5 per cent. With the use of a 22G needle in 184 cases there were 10 headaches, 5.5 per cent. Using a Whitacre (pencil-point) needle in 315 cases there were 8 headaches, 2.5 per cent. This is comparable to the original report[3] based on an even larger group.

Lumbar puncture headache is not serious or permanent and the patient should be reassured on this point. Further treatment consists of bed rest (except for necessary activity) to prevent aggravation of the headache, adequate hydration and elimination, and analgesic drugs as needed.

There were no neurological sequelae, no unusually high levels of spinal anesthesia, no toxic reactions, and no deaths related to anesthesia. In fact, the complications represented only a minor problem.

MOTOR VERSUS SENSORY ANESTHESIA

In my early use of nupercaine® I thought that while it produced excellent muscular relaxation, it provided only fair sensory analgesia. A similar doubt has been raised previously.[4] In order to test this idea, three tests were applied:

The first test was the group of 46 cases in which the nupercaine® was unsupplemented, except for oxygen from an anesthesia machine. These patients felt no pain or discomfort of any kind.

The second test was to compare the incidence of inadequate anesthesia, using nupercaine® and using pontocaine® in similar groups of cases. There was no doubt that pontocaine® provided excellent analgesia, but my experience with it antedated my use of nupercaine.® In these two comparable groups the incidence of inadequate anesthesia was 4.5 per cent with both nupercaine® and pontocaine.®

The third test was to compare the amount of pentothal® required to supplement two similar groups of 150 cases picked at random from my files, one of which received nupercaine® for spinal anesthesia and one of which received pontocaine.® In order to have a basis for comparison, the total amount of pentothal® required was divided by the duration of anesthesia in minutes, giving a calculation in milligrams per minute. In addition to the pentothal,® all of these patients received nitrous oxide and oxygen, usually in a 50:50 mixture, from an anesthesia machine, but never less than 40 per cent oxygen. Most of them were conscious when returned to their rooms, no recovery room being available.

The patients who received nupercaine® required an average of 9.5 mg. per minute of pentothal,® with a range of 3.5 to 21 mg. per minute. The patients who received pontocaine®required an average of 10.1 mg. per minute, with a range of 3 to 22 mg. Certainly there is no significant difference here, considering the number of variables. The wide range of individual variation is of interest, because I think the factor of individual variation helps explain the widely divergent reports in the literature on various phases of anesthesia.

In a few cases where an opportunity occurred to administer spinal anesthesia to the same patient for two similar operations, nupercaine® was used for one and pontocaine®for the other operation. Under these circumstances, the required dose of pentothal® in mg. per minute was identical.

Apparently my original idea about the sensory analgesia provided by nupercaine® was due to technical errors and disappeared with increasing experience.

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Cervical Trauma and Headache

FRANKLIN EARNEST III, M. D.

THAT headache is a frequent symptom of cervical disc protrusion is now common knowledge. Our attention has been forcibly called to this association by Murphy, Bucy, Raney, and others. The relationship of headache to trauma of the upper cervical roots, however, has been rather slow in delivering its impact upon the medical profession. I should like to emphasize the work of Raney and Mayfield and others in recent years in analyzing this problem.

By virtue of the anatomy of the atlas and the axis, the second cervical nerve roots have been penalized somewhat and do not enjoy the protection of the intervertebral foramina which characterizes the remaining spinal nerve roots. This nerve root peculiarly presents itself between the neural arches of the atlas and the axis and because of this location becomes immediately subject to stresses to which other nerve roots are not exposed. You will recall that the second cervical nerve, the posterior primary ramus of which is more frequently referred to as the occipital nerve, supplies approximately two-thirds of the scalp surface, a portion of the ear, the posterior margin of the cheek and mandible, and the upper margin of the neck. Stimulation of this nerve root, therefore, is accompanied by a severe pain or hemicrania experienced virtually over the major portion of the scalp, the side of the face, and the neck.

Mayfield has postulated that rotary motions of the head in excursions beyond their normal range expose the second cervical nerve root to direct trauma in a pinchers phenomenon between the neural arches of the first and second cervical vertebrae and with such vulnerability to trauma it may therefore be responsible for certain instances of unilateral head pain. The trauma responsible for this event may take the form of a whip-like action of the neck, an accordian-like action on the cervical segment as a result of a blow to the vertex, or a severe twisting motion of the neck.

The following case presentation illustrates this clinical syndrome:

CASE REPORT

The patient, a public accountant, male, age twenty-eight years, was first seen by me in consultation on May 21, 1951.

Past History: At that time he stated that on March 26, 1951, he was a passenger in a taxi which was struck from the rear by a transport truck. He was temporarily dazed but did not lose consciousness. Upon regaining his orientation he was immediately aware of a severe pain in the neck region radiating toward the left occiput. He was immediately hospitalized for 24 hours but upon leaving the hospital he observed that he was not able to walk well and stated he tended to veer toward the left. He was troubled also by mild stiffness of the neck, brief episodes of blurring of vision, and severe vomiting which became a daily occurrence. His major complaint continued to be pain in the left occipital region with radiation forward over the entire left side of the head.

The patient's neurological examination upon this initial visit was negative except for slight hypesthesia in the zone of C2 on the left and point tenderness upon deep pressure in the region of C2 and along the course of the occipital nerve.

Hospital Admission: Because of the severity of the patient's complaints he was admitted to the hospital for a more thorough investigation. Because the symptoms suggested the possibility of an intracranial space occupying lesion, pneumoencephalography was performed. The sulci markings, the cisternae, subarachnoid space, and the entire ventricular system filled normally and the manometrics at the time of the test were found to be normal. The analysis of the spinal fluid was also within normal limits.

Treatment: The patient was placed in cervical traction with almost immediate relief of headache. He was advised to continue this form of treatment at home, which he did, but was disturbed to find that although he was provided with relief upon applying his traction, upon releasing it and attempting to return to work his pain returned.

Second Hospital Admission: The patient was then rehospitalized and pantopaque® myelography was performed which revealed no filling defects. The patient was again placed in cervical traction and advised that rhizotomy of the second cervical nerve root would be necessary to provide him with relief. Because of the medicolegal implications of this case and an impending law suit the patient preferred to defer surgery and he was therefore dismissed from the hospital.

During the ensuing months he grew progressively worse. He continued to vomit virtually every day. In addition to his complaint of severe head pain with associated dizziness and disturbance in balance, he became so preoccupied by these disturbing symptoms and so concerned about his general welfare that he became severely depressed and on occasions found himself doing peculiar things, such as putting his shoes in his bureau drawer, getting dressed for work at 3 o'clock in the morning, and other bizarre maneuvers. He lost 40 pounds of weight and eventually,

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because of inefficiency, lost his position as a public accountant.

Third Admission: Feeling that he could no longer delay treatment, in spite of the unsettled nature of his law suit, he returned and was admitted to the hospital. For reassurance and thoroughness, both the myelogram and pneumoencephalogram were repeated with again normal findings. The patient was investigated carefully by a competent internist because of the complaints of nausea and vomiting with no additional light thrown on the problem.

Operation: On February 18, 1952, a sensory rhizotomy of the second and third cervical nerve roots on the left side was performed. Upon awakening, the patient stated he was relieved of his head pain.

Follow-Up: Examination three months later revealed that the patient had not vomited since the operation and had had no head pain. He had regained approximately 30 pounds of his 40 pounds weight loss and he had returned to work. A more recent check on February 7, 1953, reveals that the patient continues to be symptom free and completely rehabilitated.

DISCUSSION

This case, I feel, clearly emphasizes the incapacitating nature of this particular syndrome. The patient in retrospect volunteers that he was little short of suicide because of the persistence and the severity of this degree of pain.

It is my feeling that this syndrome is not a rarity but on the contrary is a rather frequent cause of hemicrania. It should be thought of when a patient presents a history of trauma to the head or neck and the complaint of pain localized in the occipital region, usually unilateral, accompanied frequently by nausea and lightheadedness. As in this case, the neurological examination is usually negative except for localized deep pressure tenderness in the region of the second cervical segment and along the course of the occipital nerve with associated hypesthesia. The adjunct tests of spinal fluid analysis, myelography, and pneumoencephalography are negative. The patient is usually relieved by cervical traction which in itself may induce a remission. Novocaine® injection of the second cervical nerve root will also occasionally provide relief and may assist materially in the diagnosis. Occasionally there is hyperreflexia of the lower extremities and a definite ataxia with a tendency to veer to one side.

Although the mechanism of the production of pain in these cases seems evident, I have not been entirely satisfied with the explanation of the associated symptoms so frequently seen—nausea, vomiting, dizziness, ataxia, and the hyperreflexia in the lower extremities. Since these symptoms are somewhat transitory and are reversed by rhizotomy it seems well within the realm of possibility to me that these symptoms may reflect associated spasm of the vertebral artery which may be stimulated reflexly by sympathetic fibers in the C2 nerve root causing vasoconstriction and relative ischemia of the brain stem with associated neuronal changes. Further observation will be necessary to verify this clinical impression.

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Senile Nodular Thyropathy Diagnosis

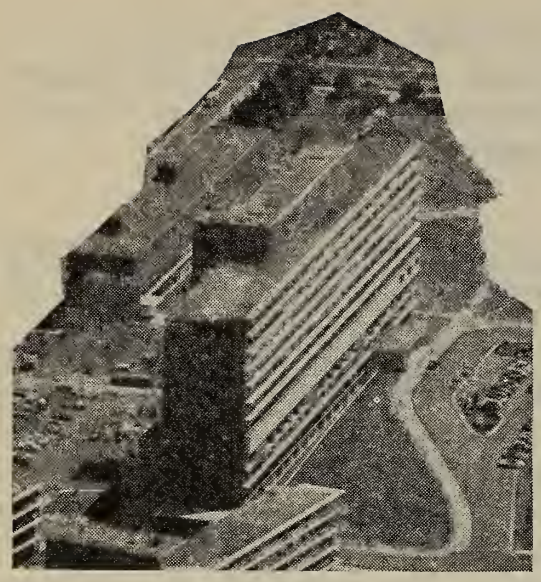
The willingness to accept the more common explanation for the cardiac disability, such as arteriosclerotic heart disease and/or coronary insufficiency, not only decreases the diagnostic acumen but limits the therapeutic possibilities for a remediable condition.

Thyrotoxicosis should be suspected in all elderly patients with auricular fibrillation who fail to respond to the accepted form of therapy.

In a combined series of 805 cases of nodular goiter, auricular fibrillation occurred in 14 per cent of the cases. A review of 2,958 cases of auricular fibrillation in the literature revealed the presence of thyroid disease in about 9 per cent. This inefficient type of rhythm is present in 85 per cent of all cases of congestive heart failure associated with hyperthyroidism and is the major factor in the production of congestive heart failure in thyroid disease.

The absence of the classical symptoms of hyperthyroidism is a characteristic feature. The fallacy that an increased basal metabolic rate is an essential diagnostic criterion adds to the pitfalls of an inaccurate diagnosis. The basal metabolic rate is often normal or only slightly elevated. In a series of 22 toxic nodular goiters, the basal metabolic rate varied from a minus 12 to a plus 42 with an average of plus 28. In a group of 70 nodular and 30 diffuse goiters with clinical evidence of thyrotoxicosis, the basal metabolic rate ranged from a minus 5 to a plus 19 in 78 per cent of the cases. In our series the range was from minus 15 to a plus 79 with an average of plus 26.9.

A decreased circulation time, which is affected by anemia, fever, B avitaminosis and congestive heart failure, may be suggestive of hyperthyroidism but is not diagnostic. A therapeutic trial with Lugol's has the disadvantage of a lengthy period of observation and delays the use of radioactive iodine.—Harold H. Joffe, M. D., Duluth; *Minnesota Medicine*, 36:145, Feb., 1953.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Edward Goodsitt, M. D., President

Presented by P. T. Knies, M. D., and E. von Haam, M. D. Edited by E. von Haam, M. D.

PRESENTATION OF CASE

A TWENTY-FOUR-year-old white woman had been in good health except for infantile eczema until 15 months before her first hospital admission when dyspnea, frequent colds and asthma thought to be due to sinusitis developed. On several occasions she had produced blood-streaked sputum.

Physical examination on her first admission revealed a well-developed and nourished young white woman with a temperature of 100.6°, pulse 100, respirations 30, and blood pressure 88/60. An eczematoid scaling was noted behind the ears. There was tenderness over the left lower chest with rales at the left base. The heart was not abnormal, and the remainder of the physical examination disclosed no significant findings.

LABORATORY EXAMINATION

The initial red blood count was 4,350,000, the white blood count 34,200 with 52 per cent polymorphonuclear neutrophils and 36 per cent polymorphonuclear eosinophils. The urine contained 20 mg. of albumin, 4 red blood cells and 10 white blood cells per high power field. Phenolsulfonphthalein excretion was 33 per cent in 1½ hours. Blood sugar, CO_2 combining power, and blood chloride determinations were normal, the blood urea nitrogen 15.5 mg. Repeated sputum examinations were negative for tuberculosis but questionably positive for Giardia. Stool examination was negative for parasites. Serologic tests for syphilis and cold agglutinations were negative. Chest x-ray revealed bronchopneumonia, which cleared during the patient's hospital stay, and marked enlargement of the cardiac silhouette, which developed while the patient was in the hospital. Electrocardiogram showed sinus tachycardia and later also evidence of myocardial and pericardial damage.

While in the hospital the patient developed on her hands and wrists dusky indurated nodules 3 to 10 mm. in diameter. Skin and muscle biopsy revealed no specific lesion. The patient was treated with penicillin, penicillin aerosol, para-aminobenzoic acid, sulfadiazine, and a short course of mapharsen.® She was discharged little improved and with a white blood count of 19,600, eosinophils 75 per cent.

Between her first and second admissions the patient remained at bed rest. When admitted three months after her first admission she showed weight loss, weakness of the right arm, and continued evidence of myocardial damage as shown by electrocardiogram. Her chest was clear. Her urine was loaded with white blood cells, and her stools were positive for Blastocystis hominis. The eosinophilia persisted in a slightly lesser degree. Biopsy of the skin showed only hyperkeratosis and hyperplasia of the epithelium.

THIRD ADMISSION

The third admission was precipitated by the sudden onset of severe right-sided and later generalized convulsions, the patient having had 15 such seizures during the four hours prior to admission. In addition to the previous findings physical examination revealed a blood pressure of 160/110, lethargy, and absence of all deep reflexes. The hemoglobin was 8.9 Gm., the white blood count 12,250 with eosinophils varying from 28 to 53 per cent. The spinal fluid contained 5 red blood cells per cu. mm., 50 mg. albumin, and had a gold curve of 0111110000. The sedimentation rate was 106 mm. in an hour. The total protein was normal with reversal of the A:G ratio.

The patient was treated with vitamin C, rutin, nicotinic acid and penicillin, and amytal® was given for sedation. She had several convulsions

while in the hospital, following which her temperature rose as high as 107°F. Skin biopsy on this admission was reported to show a dermatofibroma (sclerosing hemangioma). Her course in the hospital was continuously downhill and the patient was discharged to home care.

She returned in five days, following the onset of another convulsion. Physical examination revealed marked weight loss, stupor, scattered crusted and blood-engorged skin lesions over the exposed parts, and increased weakness in the left arm. Bleeding from the gums and rectum, bilateral basal rales, and enlargement of the heart to the left with systolic and presystolic apical murmurs were also noted.

The hemogloblin was 5.95 Gm., rising following transfusions but falling again to 5.2 Gm. The white blood count ranged from 18,400 to 30,000 with only 1 to 4 per cent eosinophils. The prothrombin was 40 per cent. The urine contained many white blood cells, E. coli, and 200 mg. of albumin. The patient's temperature ranged from 103 to 104°F. and the pulse over 110. She passed large blood clots from the rectum, developed Cheyne-Stokes respirations, and despite transfusions and other supportive therapy expired on the eighth hospital day, approximately ten months after her first hospital admission.

CLINICAL DISCUSSION

Dr. P. T. Knies: This was an individual in whom most of the attending staff of the hospital were deeply interested at one time or another. Her asthma was first thought to be of an allergic nature, but no inhalant or ingestant allergens could be found and it was concluded that bacterial allergens of undetermined nature must represent the basis for the asthma. All attempts of desensitization to bacterial antigens were unsuccessful.

When the patient was admitted for the first time a pneumonic infiltration of the base of the left lung was recognized. After that she developed an infiltration of the right apex and right mid-lung, which however did not respond satisfactorily to penicillin or sulfonamides. The electrocardiogram during her first admission showed changes which were interpreted as myocardial damage or could be attributed to pericardial effusion. The latter diagnosis was supported by the fact that radiologically the heart was increased in size.

An outstanding laboratory finding was the consistent eosinophilia. For this reason painstaking examinations for all factors responsible for eosinophilia were made, but no trichinosis or parasites were found. The possibility of eosinophilic pneumonia or Loeffler's pneumonia was considered, but no differential white count of the sputum was performed.

The possibility of leukosarcoma or periarteritis nodosa suggested themselves. However, a biopsy of the skin and muscles proved negative. Funduscopic examination showed only narrowing of the vessels of the fundus. It was during this phase of her illness that the nodules on the left hand developed. Para-aminobenzoic acid was employed for this lesion, without any clinical effect.

The individual ultimately was discharged on her own insistence with the hope that further convalescence might progress at home. When she returned she showed considerable weight loss although she still was well enough nourished. She now had developed nausea, vomiting and diarrhea. At the same time the muscle power in her right arm was diminished and pressure over the right brachial artery was painful. This suggested involvement of the central nervous and the vascular systems. Her skin showed slight pigment infiltration with hyperkeratosis which was thought to be due to local application of heat. A slight cystitis was present and colon bacillus was cultured from the urine.

The neurological examination revealed scattered anesthetic areas, and the psychiatrist suggested the presence of psychomotor hysteria. The eosinophilia had diminished to 30 per cent. During this admission symptoms from her nervous system became quite prominent and the patient was found occasionally confused, delirious and convulsive.

CONVULSIONS

The third admission was occasioned by multiple convulsions which could not be controlled by ordinary barbiturates. The muscular atrophy of the right hand was more marked. A repeated skin biopsy from one of the scattered skin nodules she had developed was diagnosed as a sclerosing hemangioma. When I examined the right fundus I noticed a periarterial nodule in the temporal field. During the attacks of convulsions the patient became febrile and a difference in skin color and moisture could be observed on the two sides of the patient. Her final admission followed the persistence of convulsions at home. Now the weight loss had become quite marked. The skin lesions had become confluent, hemorrhagic and crusted. The patient bled from the gums and the rectum. The eosinophilia had dropped to 1 to 5 per cent. She was not severely anemic.

In thinking of a single entity to explain the entire syndrome one has to consider a disease which affects widely distributed tissues. Affection of nervous tissue does not seem to explain all the symptoms, particularly those coming from the lung. Vascular and connective tissues are of course the most widely distributed ones of all. The possibility of eosinophilic leukemia was discarded because immature white blood cells were never observed in the peripheral blood stream

and because of the negative findings in the bone marrow biopsy.

VASCULAR DAMAGE

The patient showed evidence of considerable vascular damage. The infiltration of the lungs on the first admission with the hemorrhagic sputum, the atrophic changes in the right arm, and ultimately the additional neurological changes and convulsions made me feel that the primary point of the disease was located in the small blood vessels. The fundus examination, as indistinctive as it may have been, considerably influenced me to make the diagnosis of periarteritis nodosa. That disease is characterized by clinical features which may well fit those described in this case, and the only adverse circumstance is that it could not be confirmed by biopsy. I must admit the equal possibility of disseminated lupus erythematosus, which would also produce collagenous tissue changes, however not confined to the vascular tree. The differentiation of the two conditions is clinically extremely difficult, but I have the impression that in the earliest stages of lupus erythematosus the vascular pathology does not become quite as evident as it was in this case. Any further clinical comments will be welcome.

CLINICAL DIAGNOSIS

1. Periarteritis nodosa.
2. Disseminated lupus erythematosus.

GENERAL CLINICAL DISCUSSION

Dr. J. L. Morton: During her first admission we concurred in the diagnosis of asthma because of the very definite bronchiolar spasms which made her chest wall collapse and her diaphragm rise. During her first stay she developed patches considered as pneumonic areas. The heart showed an increase in transverse diameter and the heart pulsations were those of a large, dilated and fixed heart. It is impossible to differentiate with any high degree of accuracy between cases of pericardial effusion and cardiac dilatation due to myocardial changes. When she returned, barium enema was negative. Pericardial enlargement persisted and the lung fields had cleared.

PATHOLOGIC DIAGNOSIS

1. Lupus erythematosus with:
   (a) verrucous endocarditis;
   (b) generalized vascular lesions;
   (c) dermatitis;
   (d) kidney involvement.
2. Cerebral hemorrhage, multiple.
3. Obliterating bronchitis.
4. Multiple splenic infarcts.
5. Emaciation.

PATHOLOGIC DISCUSSION

Dr. E. von Haam: Before discussing the autopsy findings I would like to make a few remarks concerning the pathological report of the skin biopsy. The first biopsy was reported as "sight diffuse infiltration of the skin." This of course represents a report from which the clinician will profit nothing. The report of the second biopsy was "sclerosing hemangioma or dermatofibroma." This report contains some of the basic lesions present, but the interpretation was wrong due to the lack of clinical information.

In reviewing the biopsies in the light of the clinical picture, I can rule out any localized benign neoplastic process and suggest that the findings were typical of either periarteritis or dermatomyositis. At the time of her death the clinical diagnosis was that of "mysterious hemorrhagic vascular disorder involving the brain, intestinal tract, the skin and probably of the nature of either generalized periarteritis nodosa or disseminated lupus erythematosus."

AUTOPSY

The following were the essential findings at autopsy: The heart was enlarged and showed a mural endocarditis consisting of yellow firm vegetations such as have been described by Libman-Sacks as associated with lupus erythematosus. The skin lesion which the patient showed at the autopsy table was rather typical of this disease in distribution and appearance. Not typical for it were the findings in the intestinal tract. Here we found the basis for the severe blood loss of the patient during her last admission—severe submucous hemorrhages involving the entire colon and part of the small intestine. The spleen showed infarcts of different age and size, and the brain showed at least four consecutive periods of brain hemorrhage. They ranged in size from a small pea to a golf ball and showed marked color difference suggesting different age.

The microscopic examination of the heart showed perivascular and myocardial fibrosis and hyalinized masses in the endocardium superimposed by recent thrombi. These hyalinized masses apparently were not bacterial thrombi as the surrounding tissue showed no pyogenic reaction. The picture is quite typical of Libman-Sacks endocarditis. The lungs showed all evidence of bronchial disease with hyperplasia of the peribronchial smooth muscle fibers, glandular hypersecretion, and hyalinization of the basal membrane.

The spleen showed irregular areas of necrosis with hyalinization and thrombosis of trabecular and follicular arteries. Similar vascular changes were found much more prominently in the pancreas and adrenal glands. The vessel walls of the small and middle-sized arteries had been transformed into a homogeneous, highly acidophil mass surrounded by eosinophils, leukocytes and mononuclear cells. The lesion by itself was quite characteristic of periarteritis nodosa. Simi-

lar changes in the vessels of the intestinal tract were apparently the basis for the submucous hemorrhages with necrosis of the mucosa.

In the kidney in addition to scattered changes in the middle-sized vessels identical with the ones described in other organs, changes in the glomeruli were found. Hyalinization and thickening of the individual capillary loops produced the picture of "wire-loop" glomeruli so typical of lupus erythematosus.

In the interpretation of the entire picture that is before us, I am inclined to consider this a case of rather rapidly progressive lupus erythematosus with vascular changes resembling periarteritis nodosa. The age and sex of the patient, her skin lesion, and the changes in heart and kidney speak definitely for lupus erythematosus. It is known that this disease is associated with lesions in the middle-sized vessels which may often lead to hemorrhage (Klemperer). If it were a pure case of periarteritis nodosa we could not explain all the lesions found at autopsy.

GENERAL DISCUSSION

DR. KNIES: I also agree that the skin changes are not typical of periarteritis nodosa. However, I was impressed by the fact that the clinical symptoms of the patient were attributable more to injuries to larger vessels rather than smaller ones. This was the determining factor why I favor periarteritis nodosa rather than lupus erythematosus.

REFERENCES

Klemperer, P., Pollack, A. D., and Baehr, G.: Pathology of Disseminated Lupus Erythematosus. Arch. Path., 32:569-631, 1941.

Group Psychotherapy

Group psychotherapy as generally used was begun as a matter of necessity during World War II, with trained personnel limitations as the primary stimulus. Later the method was employed in hospitals where it was the only way in which the large number of patients could be seen. The benefits, the gains, and the improvements of the patients treated in this manner encouraged some psychiatrists to try it in private practice. The results have been similarly successful and beneficial.

It was some time after the positive results of group therapy had been established that it was recommended for financial reasons. It is presented as a way of enabling the therapist to see more patients and at the same time to offer for less money a type of treatment which is known to be efficient. In reality the patient can regulate his own price. He may decide how often he will attend group sessions and with how large a group he will affiliate himself.Earl Parsons, M. D., Little Rock; *J. Arkansas M. Soc.;* 49:219, May, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Chronic—This term refers directly to time and is derived from the Greek word "chronos" or time. Hence as applied to diseases the term refers to diseases that continue for a long time. The use of the term in this sense is very ancient and began with Hippocrates.

Exercise—To exercise at first meant to let people, slaves or animals out of confinement, in order to put them to work or to give them a chance to play. The term comes from the Latin "ex" or out and "arcere" to confine, hence it literally means to "let out of confinement." At first you always exercised someone else, but as the word grew more pleasant in its meaning, you, yourself might take "exercise."

Prostitute—A term derived from the Latin word "prostitutus," which means, placed or set forth openly. The term comes from the Latin "pro" or before and "status," I place. Hence it means that which is placed up for hire or thus a female placed before the public for hire.

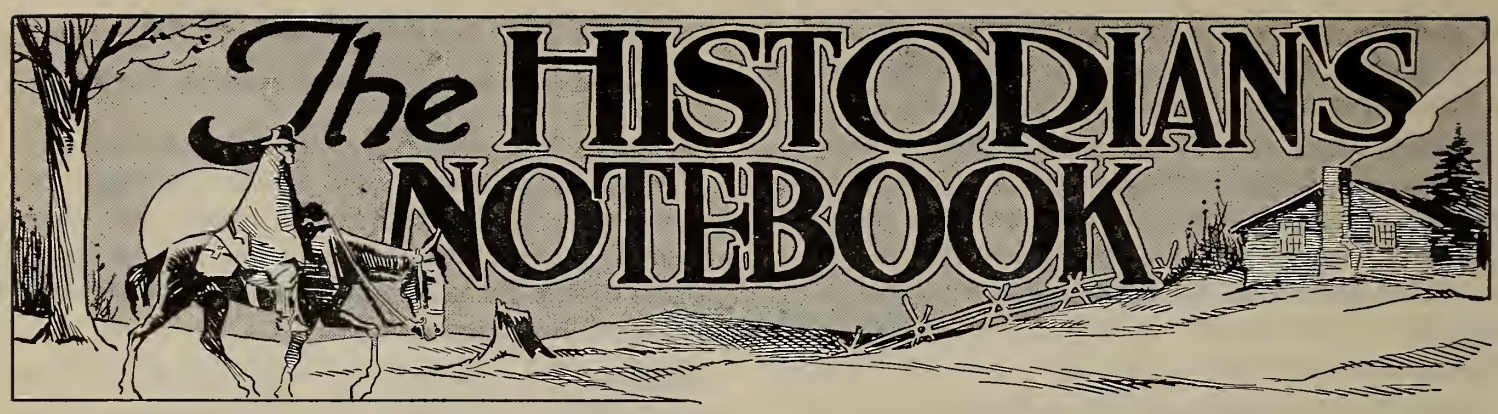
Disaster — When doctors render emergency service in a disaster little do they believe that the disaster was due to an improper arrangement of the stars. However, this word is derived from this old superstitious belief, and the term is composed of the Latin word "dis," or apart, and the Greek word "aster" or star. Hence disasters occur when the stars are away from their proper or propitious places.

Diet—Medically this term now denotes food prescribed as to kind and amount. It also means food and drink regularly consumed, but it originally meant a daily ration of food. The word came into English via the French word "diete" meaning daily fare. This, in turn, came from the mid-Latin word "diaeta" meaning a daily ration of food and may be related to the Latin word "die" or day.

Face—This French word which was adopted into English unchanged comes from the Latin word "facies" which at first meant appearance and then visage or countenance. The Latin word "facies" comes from the Latin "fac" as in "facem" or torch and hence means to shine, or to appear. Thus the "face" is that which shows itself—or literally a shining "face."

Family—This word now designating either a household or descendants from one common progenitor comes from the Latin word "familia" or household and this in turn comes from the Latin word "famulus" or servant. In ancient times the man was the master and the woman and children were his servants.

—HARRY WAIN, M. D., Mansfield, Ohio.



Medical Journalism in Ohio

JONATHAN FORMAN, M. D.*

PART I

THE first medical journals in the Western country were published by the faculties of the new medical colleges. Their prime purpose was to promote the interest of their respective schools, to spread their reputation and thereby to attract students. In those days, students had to be searched out and persuaded to come to a medical college. At that time also there was practically no other way through which the members of the faculty could keep in touch with their former students and with the profession in general. These early medical journals served in this way not only as a means of getting new students for their respective colleges but also, and perhaps of more importance in the eyes of the faculty, of securing private consultations for their distinguished teachers.

After the Civil War many local medical journals sprang up under the editorship of some outstanding physician of the area. In certain instances, the editor was seeking expression for the things that he himself wanted to say. In other instances, he was using the pages of his magazine to blast away at the faculty of a medical college. In a few, this was because the college had fired him from his position as a teacher. Gradually, private medical journals crowded out the publications of the medical schools and these in turn were forced to the wall by the appearance of official publications of organized medicine.

A brief glance at the check list of Ohio's medical publications will reveal that almost all of them were attached to some strong medical personality. They sprang up, merged, fought, separated, divorced, re-united or ceased publication as these personalities cooperated or failed to do so.

FEUDING

Notable among these feuds were the fights of Daniel Drake and his colleagues in Cincinnati as they moved from one school to found another and came back again to their first-born. The bitter disagreement of those members of the Willoughby faculty who insisted on moving the college to Cleveland, and the Board of Trustees and the minority of the faculty who did not want to leave Willoughby, forms the background of another fight which occurred largely in the halls of the State Legislature. The Willoughby faculty seemed to have the better political connections and were able to prevent the founders of the Cleveland Medical College from securing a charter. Fortunately, the Western Reserve College at Hudson extended a protecting wing to the new school so that it became a part, and still remains a part of the Western Reserve University.

By far the loudest, the wordiest, and the bitterest was the struggle in Columbus, later transferred to Cincinnati and continued throughout the lifetime of its leaders. When Alvin Curtis came to Columbus to edit *The Columbus Thomsonian Recorder*, it gave him a chance to carry the torch for Samuel Thomson and his school of healing. He at once entered into controversy with the faculty of the Reformed Botanical-Medical College at Worthington under the leadership of Thomas Vaughan Morrow, later to head the Eclectic Medical Institute when the reformed botanics moved to Cincinnati, and with the homeopath recently arrived from Germany, one Leopold Lehman.

Curtis was particularly bitter at the physicians of the regular school because of unfortunate

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Read before the joint meeting of The American Association of the History of Medicine and The Ohio Academy of the History of Medicine at Columbus, Ohio, on April 11, 1953.

salivation of one of his kinfolk back in New England. Even among his fellow Thomsonians, Curtis insisted upon his own authority and his right to judge them. He often lectured his associates, in print and in public, magisterially for what he considered their derelictions.

WORTHINGTON JOURNAL

In 1836, the Reformed Medical College of Worthington launched its *Journal of Medical and Chirugical Sciences* which carried as its subtitle *The Medical Reformer* with the professors of the school as its editors and proprietors. This was designed to interest the public in the Reformed Botanic system of practice and to induce young men to enter its practice as a career. Some of its case reports were as dramatic as any that the patent medicine men were ever able to assemble in the next three generations. They were well calculated to convince the reader that the Reformed system of healing was superior to all others.

The next year, 1837, was the year of the great financial depression and bank failures, and it was with the greatest difficulty that the school kept its journal going. In 1838 it became necessary to abandon it and to close the infirmary at the college. Both the Thomsonians and the Reformed physicians suffered greatly in these hard times.

In the '40's both Curtis and Morrow had removed their respective schools to Cincinnati. Times were better and both revived their medical journals. For the eclectics as they were now called, Morrow revived the *Western Medical Reformer*, for the Botanics Curtis brought to life *The Botanical-Medical Recorder*. From the Civil War days until the appearance of the Carnegie Report in 1909 on the low state of the American Medical Colleges the medical profession in Cleveland, Cincinnati, Columbus, and Toledo was divided into cliques—the coteries of one or two physicians endowed with belligerent leadership.

In the earlier days of Ohio, these journals were in fact repositories for original and selected essays on medical intelligence. Understandably enough, there was usually little of the original and much of the material was selected from other publications, so that one could trace a good "filler" from Edinburgh to Boston, to New York, to Philadelphia and out into the medical magazines of the Western country.

The tables of contents of practically every medical journal in the United States, cultist and regular, followed the same pattern. First, there was the presentation of an original essay or case studies under the head of "Original Communications"; secondly, there followed a much longer section presenting selected material from other medical publications; third, a review of recent books; fourth, general news which included items from medical schools—especially the one with which the periodical might have more or less affiliation—news from medical societies, short abstracts of medical articles, occasional editorials, and literary chit-chat.

DISCOVERIES SCARCE

In those days, in science, discoveries applicable to medicine were relatively few and far between in terms of a monthly magazine. Consequently, the original communications had to do with the cure of a disease by methods of which the author was a strong proponent—be it the exhibition of large doses of calomel, bloodletting; or the technique of the "steam and puke" doctors as the regulars contemptuously referred to the followers of Samuel Thomson; or the herbs of the Reformed Botanics. All of this we see in the last two-thirds of the nineteenth century transferred to the religious press and then to the newspapers as testimonials for certain medicines persisting with a fading emphasis even to the present and Hadacol.

Ultimately, as pure science gave the applied sciences of anatomy, pathology, and physiology tools to work with, the applied science began to give those of the healing arts who would listen, facts with which to work. Gradually, as these facts became available, one cult after another succumbed to the march of progress of human knowledge and understanding.

PATHOLOGY'S CONTRIBUTION

As pathologic anatomy, both gross and microscopical, began to reveal the changes in the bodies of men who had died of disease, medical journals assumed leadership in the profession's emphasis on diagnosis without bothering much about the treatment (for medicine had little to offer until the metabolic processes of the cell were better understood). Drake, Eberle, Gross, in Cincinnati; John Butterfield, Starling Loving, John Hamilton, in Columbus; Ackley, Delamater, Kirkland, in Cleveland were the pioneers in this field which culminated in the lives of Roger Morris in Cincinnati, Charles Hoover in Cleveland, and D. N. Kinsman and Frank Winders in Columbus.

Nationally, this trend culminated in Osler's textbook on *The Practice of Medicine* and almost obtained perfection in the "book making technique" of Richard Cabot in his *Massachusetts General Case Histories*. By knowing the frequency of a symptom in the admissions to a hospital one could and Cabot did work out a system of probabilities based upon the presenting symptoms that yielded a practical accuracy of over 90 per cent.

With all of their faults, shortcomings, and personal feuds, Ohio's medical journals did improve with the passing years. In Ohio as elsewhere in the nation, the important factors that hastened this improvement were the rapid in-

crease in the sum total of knowledge about the human body and the impact of the newly organized American Medical Association in which the leaders of Ohio Medicine in Cincinnati, Cleveland, and Columbus played such an important role.

In the transactions of the Association for 1848, we find the Committee on Medical Publications reporting: "The proportion allotted to these several divisions varies very much. Taking into consideration the usual difference of type in the original and borrowed matter and the very liberal extracts which the reviewers commonly make from the work before them, it will be found that a very large part of all journals is made up of quotations and to a considerable extent of the same quotations, whatever may be the particular journal examined.

"The committee has been struck with the fact that the same articles have been presented over and over again to the notice, in many different periodicals, each borrowing from its neighbors the best papers from the last of the preceding numbers, so that the perusal of many is not so much more laborious than that of a single one, as would be anticipated. The ring of editors sit in each other's laps, with perfect propriety and great convenience it is true, but with a wonderful saving in the article of furniture."

In the late 70's, the 80's, and the 90's the possibility that bacteria might be the immediate, if not the ultimate, cause of many, if not all, diseases furnished a rich supply of original communications. Here in Columbus, David N. Kinsman was outstanding in this field of medical writing. Dr. Kinsman, for whom our Medical and Surgical Research Building is named, read both the German and French journals religiously and wrote and spoke constantly on clinical bacteriology. His pen poured forth a constant stream of papers on typhoid, tetanus, and tuberculosis. He conditioned the minds of the citizens of Columbus to follow Dr. E. G. Horton in 1903 when he began a crusade to get a bacteria-free water in the public supply of Columbus and the other Ohio cities. Dr. Kinsman did more than anyone else to convert the physicians of central Ohio to the recognition of the validity of the "germ theory."

NEED FOR REFORMS

All through the years from the very first to the present day, the editors of the Ohio medical publications have never lost sight of the need for the regulation of the practitioners of the healing art; the importance of improvements in medical education; the development of a sound public health program and the desirability of better organization and solidarity within the profession.

In the 80's professional and trade groups began to be better organized. The State began to again regulate their activities; first, at their request and later without their leave. It inevitably became necessary to publish some kind of house organ for intra-organizational communication. It was for this reason that *The Ohio State Medical Journal* came into being.

At the time that *The Ohio State Medical Journal* was founded in 1905, there were active private medical periodicals being published in Toledo, Cleveland, Columbus, and Cincinnati. In their time, these journals served a useful purpose. At the turn of the century, however, with the rising tide of reform against the advertisements of secret remedies and the disturbing fact that the *Columbus Medical Journal,* still carrying its disguise as a reputable magazine, was in fact the house organ of the Peruna Manufacturing Company, made the future of the Ohio medical publications look very dark indeed.

The patent medicine industry was in fact driving them out of business. This industry had grown to enormous size. It was a threat to the family doctor, more so than the cults, after bacteriology had given the medical profession the means by which to win the argument that infections were caused by germs and not from any of the fanciful causes which the cults claimed. The current advances in science had also made the average physician aware of the uselessness of the widely advertised concoctions for the cure of disease. So from 1890 up to 1905 there was an increasing interest on the part of the profession in the problem of patent medicines.

In the meantime, the new discoveries of science as well as the need for reforms in both the fields of patent medicine and medical education made it important that the Ohio State Medical Society, as it was then called, have its own official organ. The old big obstacle to starting a new journal as well as keeping an old one in circulation was the oft-repeated statement of the editors of existing journals that they could not exist without the advertisements of the proprietary remedies.

(To be concluded in September issue)

Memory of Pioneer Physician Honored By Trumbull County Society

Dr. John Williamson Seely (1771-1840) was the first resident physician to the present Trumbull County. In 1806, he located in Howland Township where he cleared a farm and the following year moved his family to the new location. As part of the Sesquicentennial celebration, the Trumbull County Medical Society on June 28 made a pilgrimage to the burial place of Dr. Seely, where ceremonies were held and a wreath placed.

Proceedings of The Council . . .

Busy Sessions Held on Saturday and Sunday, July 11-12; Committees Appointed; Revisions in Workmen's Compensation Fees Recommended

MEETINGS of The Council of the Ohio State Medical Association were held on Saturday and Sunday, July 11 and 12, 1953, in the Columbus Office. All members of The Council were present except Dr. D. W. Heusinkveld, Cincinnati, and Dr. C. L. Pitcher, Portsmouth. Others in attendance were Dr. Jonathan Forman, Columbus, Editor of *The Journal*; Dr. H. P. Worstell, Columbus, Chairman of the Committee on Industrial Health and Workmen's Compensation; Dr. C. C. Sherburne, Columbus, delegate to the A. M. A.; Mr. Wayne Stichter, Toledo; and Messrs. Nelson, Saville, Page and Moore.

On **motion** duly made, seconded and **carried**, the minutes of meetings of The Council held on April 20 and April 23, 1953, **were approved.**

MEMBERSHIP STATISTICS

The Executive Secretary reported on membership as follows: Total number of members in the State Association as of July 10, 7,742; compared to a total membership of 7,806 as of December 31, 1952.

Total number of State Association members affiliating with the A. M. A. as of July 10, 1953, 6,589; compared to a total of 6,442 as of December 31, 1952.

The annual audit by Keller, Kirschner, Martin & Clinger, certified public accountants, of the books of the Ohio State Medical Association and The Ohio State Medical Journal for the calendar year 1952 were submitted and approved, on **motion** duly made, seconded and **carried.**

FINANCIAL QUESTIONS

Bids from various firms for air conditioning the Columbus office were reviewed. Action was deferred until the December meeting of The Council.

On **motion** duly made, seconded and **carried**, an amount not to exceed $50.00 for State Association trophies for participants in the 1953 Annual Tournament of the Ohio State Medical Golfers Association was approved; and it was recommended that a similar contribution be made annually.

The attention of The Council was called to the fact that Doctor Robert Conard had turned over the chairmanship of the Military Advisory Committee to Dr. Drew L. Davies, Columbus, and that Doctor Davies is now carrying on these activities in conjunction with the clerical staff of the Columbus Office.

WORKMEN'S COMPENSATION

A voluminous report from the Committee on Industrial Health and Workmen's Compensation was presented for official action by Dr. H. P. Worstell, chairman of that committee. The report consisted of proposed changes in the Workmen's Compensation Medical and Surgical Fee Schedule and in some of the rules of the Industrial Commission applying to physicians. The report was prepared by the committee after six meetings of the committee and after reviewing more than 100 suggestions received from County Medical Societies, groups of specialists, the Ohio Academy of General Practice, and individual physicians.

After a review of the report, The Council, on **motion** duly made, seconded and unanimously **carried**, approved the report, with minor amendments, and instructed Dr. Worstell to present the recommendations officially to the State Industrial Commission with supporting data.

LEGISLATURE AND CONGRESS

A report on the Ohio General Assembly and the Congress was presented by the Executive Secretary. The Council, by official action, expressed appreciation to the officers and legislative committeemen of the County Medical Societies, the State Legislative Committee, individual physicians who assisted on legislative matters, and members of the Columbus Office Staff for the very good work done by all during the current session of the Ohio General Assembly, during which no bills detrimental to public health or to the medical profession were enacted and a number of measures supported by the Association were passed.

STUDY COMMITTEE DESIGNATED

Certain members of The Council suggested that a committee be designated to make a thorough survey of the situation relating to the construction of additional hospitals by the State of Ohio for all types of patients and of the laws, procedures, rules and regulations, etc., governing the operation of existing hospitals financed or operated by the State. The proposed study would include hospitals for the mentally ill; feeble minded and epileptics; receiving hospitals; tuberculosis hospitals and other hospitals which might be contemplated for the care of persons suffering from specific diseases or disabilities.

Following a prolonged discussion, the President, with the approval of The Council, designated

the following committee to undertake this study, investigation and analysis: Committee on Public Relations and Economics; the chairman of the Judicial and Professional Relations Committee; the chairman of the Committee on Chronic illness; chairman of the Subcommittee on Cancer; and the chairman of the Subcommittee on Mental Hygiene.

PUBLIC ASSISTANCE STUDY

President Davis announced the Committee on Public Relations would start meetings in the near future to study the public assistance laws and programs of the State, taking into consideration many recommendations received from County Medical Societies and others; and that the committee, following its study, would confer with officials of the Division of Public Assistance and Division of Aid for the Aged on such matters.

Action of the Executive Secretary and Business Manager of *The Journal.* rejecting advertising submitted by Kent Cigarettes because such advertising contained medical and health claims, was approved.

COMMITTEE ON EYE PROBLEMS

A letter from Dr. Arthur M. Culler, Columbus, suggesting that the Association establish a Committee on Interprofessional Relations, consisting of ophthalmologists, optometrists and opticians, was considered. Following a discussion the President was authorized to appoint, after consultation with the chairman of the Committee on Public Relations and Economics, a subcommittee of that committee, consisting of three opthalmologists, the functions of the subcommittee to be to confer with optometrists and opticians on questions of mutual interest and to make its reports to the Committee on Public Relations and Economics for review and action.

The Council, by official vote, approved the program of the Ohio Employ the Physically Handicapped Committee and recommended that all County Medical Societies cooperate with local committees, especially in the selection of candidates among members of the medical profession for the "Physician's Award," made annually by the National Committee on Employment of the Physically Handicapped.

HOSPITALIZATION QUESTIONS

Dr. Nicholas Michael and Dr. J. J. Alpers, Columbus, representing the Central Ohio Neuropsychiatric Society, appeared before The Council, asking that The Council assist in efforts to get Central Hospital Service to provide hospital service coverage for psychiatric cases. They stated that Central Hospital Service and the Blue Cross Plan in Toledo are the only Blue Cross Plans in Ohio which do not provide hospitalization coverage for psychiatric cases. It was pointed out that because of this, psychiatric patients who hold contracts in these two plans often are compelled to seek hospital and medical care from State institutions, thus seriously interfering with the private practice of psychiatrists in the two areas.

The Executive Secretary reported that this question had been raised before and that The Council had requested the Association of Blue Cross Plans of Ohio to try to work out uniform coverage for psychiatric cases and that the matter is now under consideration by a special committee of that organization.

After a thorough discussion The Council referred this matter to Dr. E. H. Artman, Chillicothe, Councilor of the Tenth District, with a request that he discuss this matter with officials of Central Hospital Service in an effort to get that organization to expand its coverage to hospitalization of psychiatric cases.

Dr. Michaels also pointed out to The Council that many patients who can afford hospital and medical services from private hospitals and private physicians are being accepted into the state institutions and receiving hospital care without charge or at a very nominal charge. The Council advised him that this matter would be referred to and considered by the special committee designated by the President to study the whole question of hospital building and hospital procedures by the State.

WOMAN'S AUXILIARY

Mrs. N. M. Reiff, Washington C. H., President of the Woman's Auxiliary to the Ohio State Medical Association, appeared before The Council for the purpose of discussing with The Council the program and activities of the Auxiliary. Among other things, Mrs. Reiff advised The Council that the Auxiliary would like permission to secure advertising for the official magazine of the Auxiliary in an effort to make the magazine self-supporting. She outlined plans for a contemplated issue with advertising, sometime this Fall. By official action, The Council recommended to Mrs. Reiff that advertising be published in the Fall issue of the Auxiliary magazine on a trial basis and authorized Dr. J. S. Hattery, Mansfield, chairman of the Advisory Committee to the Auxiliary, to assist in the screening of advertising.

RURAL HEALTH

Mr. Page reported for the Committee on Rural Health. He stated that Dr. E. K. Yantes is the new chairman of that committee, having succeeded Dr. J. Martin Byers, Greenfield, who has entered active military service, the appointment having been made by President Davis at the time of Dr. Byers' resignation. Mr. Page also reported that the committee had reviewed the applications of nine applicants for the 1953 Ohio State Medi-

cal Association rural medical scholarship and that a final decision would be made by the committee at its next meeting late in July.

HEALTH EDUCATION

Mr. Page advised The Council that the State Planning Committee for Health Education in Ohio, on which the Ohio State Medical Association is represented, desires to sponsor an Ohio conference next Spring similar to the Highland Park Conference on Physicians and Schools sponsored by the American Medical Association.

He pointed out that the Ohio conference would be limited to 50 or 75 persons directly interested in health education. By official action The Council approved the project and instructed the Committee on School Health and Mr. Page to assist in working out details for the proposed Ohio conference.

AD RATES INCREASED

The Executive Secretary and Managing Editor of *The Journal* presented a report on expenditures and disbursements involving *The Ohio State Medical Journal.* Inasmuch as advertising rates charged by *The Journal* have not been increased since January 1, 1951, by official action The Council authorized a 15 per cent increase in advertising rates, effective January 1, 1954.

MISCELLANEOUS ACTIONS

The Executive Secretary was authorized to plan for an Ohio State Medical Association Special Train to the A. M. A. meeting in San Francisco, June 21-25, 1954, if conditions warrant, without any financial obligation on the part of the State Association.

The Council authorized a conference of executive secretaries of local medical societies in Columbus on the week-end of September 25-26.

On behalf of the Toledo Academy of Medicine, Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District, presented a request that the State Association take up with the Department of Public Welfare the matter of devising a shorter form to be used by physicians in certifying persons for hospitalization in the mental institutions of the State. It was suggested that a form like the one used in the State of Connecticut might be adopted. This question was referred to the Committee on Mental Hygiene for study and a report.

Following reports by members of The Council on activities in their respective districts, The Council adjourned to meet at the Granville Inn, Granville, Ohio, on the week-end of October 2-4.

Attest: CHARLES S. NELSON,
Executive Secretary.

Dr. Heusinkveld Heads Ohio Tuberculosis Association

Dr. David W. Heusinkveld, Cincinnati, was elected president of the Ohio Tuberculosis and Health Association. Dr. Heusinkveld is Councilor of the First District, Ohio State Medical Association.

Other officers are: William M. Morgan, Ph. D., Alliance, first vice-president; Raymond C. McKay, M. D., Cleveland, second vice-president; Joseph B. Stocklen, M. D., Cleveland, secretary; William A. Brungs, Columbus, auditor; and William G. Bope, Columbus, treasurer. Among those elected to the Executive Committee were the following physicians: Drs. Lynne E. Baker, Dayton, and Max I. Durfee, Oberlin.

World Medical Ass'n and Editors To Meet in Netherlands

The seventh general assembly of the World Medical Association will be held at The Hague, Netherlands, August 21-September 5. Additional information may be obtained from the World Medical Association, 345 East 46th Street, New York 17.

Following the assembly, the fourth annual medical journalism meeting, sponsored by the World Medical Association, will be held in the Parliament Building in the same city, on September 7.

If you are moving to a new location or for other reason plan to change your address, please notify the Headquarters Office as early as possible so that your copy of *The Journal* and other mail may be sent to you without delay.

FOR YOUR CONVENIENCE CLIP AND MAIL

To: The Ohio State Medical Association,
79 East State Street,
Columbus 15, Ohio

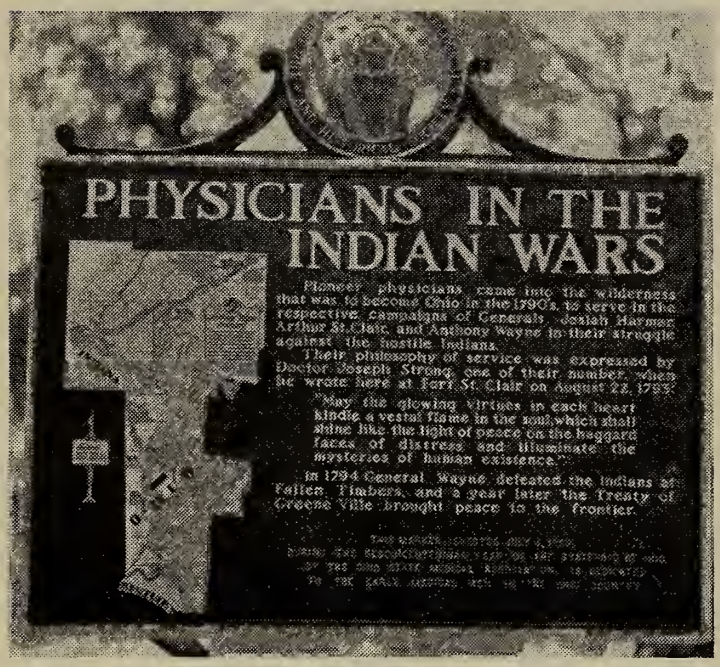
Name_____

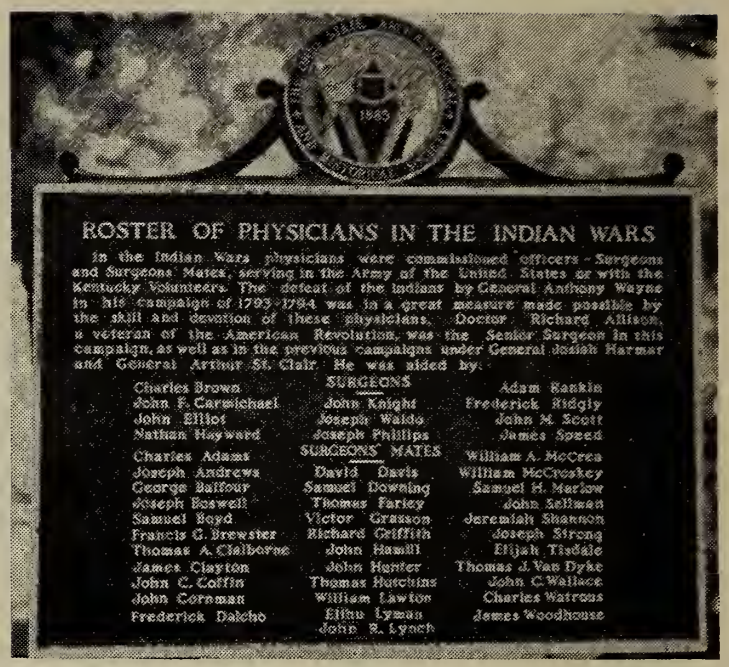
New Address_____

City_____ Zone_____ State_____

Former Address_____

Marker Honors Pioneer Physicians . . .





Shown above are the two sides of the marker erected on the site of Fort St. Clair in honor of physicians who took part in the Indian Wars. The marker records the part played in the Wars by physicians, pinpointing on a sketch major events in the campaigns. It also gives a roster of these pioneer physicians. The plaque was sponsored by the Ohio State Medical Association in collaboration with the Ohio Archaeological and Historical Society, as part of the Ohio Sesquicentennial celebration.



Taking part in dedication ceremonies on July 4 at Fort St. Clair are left to right: Dr. A. L. Ross, West Alexandria, president of the Preble County Medical Society; Dr. Merrill D. Prugh, Dayton, President-Elect of the Ohio State Medical Association; Dr. Paul A. Davis, Akron, President of the Ohio State Medical Association; Miles S. Kuhns, of the Anthony Wayne Parkway Board; and Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal* and professor of the history of medicine at Ohio State University. At the speaker's roster as this picture was taken was Clifford Cottingham, Eaton, district supervisor of the Ohio State Archaeological and Historical Society.

Doctor Draft Act Analyzed . . .

Digest Prepared by Washington Office of A.M.A. of Public Law 84 Effective July 1; Reenacted Law Carries Many A.M.A. Suggestions

ON June 29, President Eisenhower signed the bill passed by Congress, extending and amending the Doctor Draft Act. It is identified as Public Law 84, Eighty-Third Congress and will be in effect through June 30, 1955.

Following conferences with government officials regarding provisions of the law, the Washington Office of the American Medical Association drafted the following digest of the provisions of Public Law 84:

WHO MUST REGISTER UNDER THE DOCTOR DRAFT LAW?

All physicians, dentists and veterinarians not members of an armed service reserve component and under 50 years of age must be registered with their local draft board. They remain liable for induction up to age 51. Men on graduating from medical school have **10 days to register and ask for deferment for a year to complete internships.** A physician must register under the doctor draft even though he has previously registered for the regular draft.

HOW MUCH SERVICE IS REQUIRED UNDER THE LAW?

Maximum service under the doctor draft is 24 months, which is required of all physicians who have had less than nine months of prior active duty. Graduated periods of service are provided for others as follows: 21 months if prior duty ranges between nine and 12 months, 18 months if prior duty ranges between 12 and 15 months, and 15 months if prior duty totals 15 or more months. The foregoing is applicable to reservists as well as registrants under the act. (While the law sets up a schedule of obligated duty based on prior service, it should be remembered that **there is almost no chance of priority IV men being called during the two years, barring a general war or other national emergency.)**

In addition, **priority II doctors with 17 or more months' service prior to entry on current duty are classified in priority IV, and no doctor with 21 months' prior service can be called during the life of the present act,** except in time of war or national emergency declared by Congress. The law also requires release within 90 days of all men on active duty who would not have been called had the new law been in effect, but they **must apply for release.** (The 17 months of service referred to in this paragraph is used solely for the purpose of priority classification. It should not be confused with the schedule set up in the preceding paragraph which is used to determine the order in which men with prior service will be called to active duty, if needed.)

WHAT CHANGES ARE MADE IN THE PRIORITIES?

The new law continues the four priorities, but effects two changes of importance: (A) It lowers from 21 to 17 months the amount of active duty required to move a man from priority II to priority IV. (B) It credits **all active duty of any nature** subsequent to September 16, 1940, except as noted in next question (the old law credited only service performed subsequent to receipt of professional degree).

(Priority I doctors are those who either received all or part of their professional education at government expense or received educational deferments in World War II, and who served less than 90 days on active duty. Priority II are those similarly educated or deferred, but who served between 90 days and 17 months—21 months under the old law. Priority III are men with no military service. All others make up priority IV. Priorities I, II, and III will be called before priority IV.

WHAT IS THE DEFINITION OF PRIOR ACTIVE DUTY?

The law defines active duty as time spent either as **enlisted man or officer** since September 16, 1940, on (1) active duty in Army, Navy, Air Force, Marine Corps, Coast Guard, and U. S. Public Health Service, (2) non-military duty prescribed for conscientious objectors, (3) wartime military service with any World War II ally of the United States, and (4) service with the Panama Canal Health Department during World War II.

Not counted as active duty is time spent under military auspices in (1) ASTP, V-12 or similar training programs, (2) intern, residency or other postgraduate training, (3) senior student programs prior to receipt of the appropriate degree, (4) active service performed for sole purpose of undergoing a physical examination, and (5) active duty for training entered into subsequent to enactment of the law.

WHO IS ELIGIBLE FOR DEFERMENT?

Local boards, advised by state or local medical advisory committees to Selective Service, may defer doctors for (1) essentiality to the community, (2) extreme personal hardship, (3) certain teaching posts in medical schools, and (4) essential laboratory and clinical research.

DOES LAW PROVIDE FOR CONTINUING EQUALIZATION PAY?

The $100-a-month equalization pay is continued for all commissioned physicians and dentists (except interns) while on active duty and is extended to veterinarians.

IS IT POSSIBLE TO RESIGN COMMISSION?

Physicians obligated only under the doctor draft **are discharged** from their commissions on completion of active duty performed in carrying out doctor draft obligations, retroactive to cover all who have served a year or more since September 9, 1950 (enactment of original doctor draft law). Reservists who would be liable for doctor draft except for their membership in a reserve component **may resign** their commissions upon completion of the period of obligated service. However, permissive resignation is not extended to those who are obligated by law or contract to serve on active military duty or in training in a reserve component.

ARE ALIENS ELIGIBLE FOR A COMMISSION?

A registrant under doctor draft no longer is held ineligible for appointment as an officer on sole ground he is not a citizen of the U. S. or has not made a declaration of intent to become a citizen.

HOW IS DUTY IN U. S. PUBLIC HEALTH SERVICE CREDITED?

Full credit is given for service in the commissioned corps of U. S. Public Health Service. PHS, unlike the military, may not hold a man against his will. Consequently, under the old law it would be possible for a doctor to serve in PHS for a few days, then resign and give up his commission, and move to priority IV. To forestall this, the new law requires that the Surgeon General of PHS approve termination of a commission if the time served is to be credited under the doctor draft law.

OTHER POINTS

Since the doctor draft law is part of the Selective Service Act, men covered by the law are subject to the Selective Service System up to the time they accept commissions . . . The law, as it affects doctors in service, is administered under regulations laid down by the three armed forces, within the limitations of the law . . .Selective Service has nothing to do with determining the commission or promotion to which a doctor is entitled; this is the province of the three services, which are required by law to grant commissions "commensurate with professional education, experience or ability" . . . Time spent in PHS internships and residency training programs, like military programs, is not credited as active duty.

GREATER RECOGNITION OF PRIOR SERVICE

In considering the over-all effect of the new law it should be noted that the major changes involve greater recognition of prior military service. The result is that a particular registrant, by being able to take advantage of the various new provisions, may either (a) become exempt from liability for service, (b) be placed in a priority less vulnerable to immediate call, (c) be subject to a reduced term of service, or (d) effect a severance of military status within 90 days upon application or after the completion of his period of service by being either discharged or permitted to resign. These amendments will remove many of the inequities which now exist.

MOST A. M. A. RECOMMENDATIONS FOLLOWED

Many of the recommendations made by the American Medical Association in its testimony before the Armed Services Committees of the House of Representatives and the Senate were accepted. Those which were modified or rejected are:

The Association recommended that the liability for registration and call-up of veteran physicians in priority IV, as well as the involuntary recall of medical reservists in this category, be terminated as of July 1, 1953.

(The law, as enacted, excuses from further liability those registrants and reservists in priority IV with 21 months or more of service since September 16, 1940. This amounts to substantial acceptance of the Association's recommendation since between 85 and 90 per cent of the physicians in priority IV have 21 months or more of service.)

The Association recommended that the second period of duty be limited to 12 months for a registrant or a reservist who had 12 or more months of previous service. (The law, as enacted, establishes a staggered period of service.)

The Association recommended that all accrued or terminal leave as well as travel time be included in computing total active duty.

(Such credit was not allowed. The Armed Services Committee of the House of Representatives indicated that the reduction from 21 to

17 months to qualify for priority IV was intended to take care of inequities of this type.)

The Association recommended that the reserve commissions of doctors called into service by operation of the "Doctor Draft Law" should not be vacated automatically upon completion of required service. It was the belief of the Association that doctors should be given the option of retaining or resigning their commissions. It was further recommended that reserve officers in the Navy and Marine Corps with service in World War II be permitted to resign their commissions immediately if they wished to do so. (The recommendations of the Association in this regard were not accepted.)

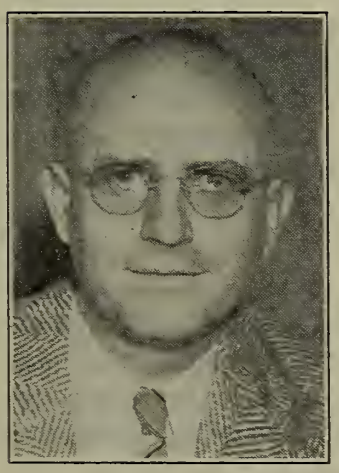
The Association recommended that any extension of the "Doctor Draft Law" be limited to one year. (The law was extended for two years.)

New Military Advisory Chairman . . .

Dr. Conard Retires After 33 Months of Excellent Service; Dr. Drew L. Davies, His Successor, To Carry On Work Through Columbus Office

AFTER 33 months of full-time service as chairman of the Military Advisory Committee of the Ohio State Medical Association and chairman of the Ohio Advisory Committee to Selective Service under the direction of the National Advisory Committee, Office of Defense Mobilization, Dr. Robert Conard has tendered his resignation of both posts in order to lead a life of retirement in his home city of Wilmington.

In accepting Dr. Conard's resignation as chairman of the O. S. M. A. Military Advisory Committee, The Council expressed sincere regrets and highly commended him for his loyal and efficient services during the Korean emergency, as well as for his outstanding work in a similar capacity during the Procurement and Assignment days of World War II.



DR. DREW L. DAVIES

After accepting Dr. Conard's resignation, The Council appointed Dr. Drew L. Davies, Columbus, as chairman of the Association's Military Advisory Committee, to serve on a part-time basis, effective July 1. Dr. Davies also has been appointed chairman of the Ohio Advisory Committee to Selective Service by the National Advisory Committee. Dr. Davies has accepted both appointments.

The Ohio Advisory Committee to Selective Service in addition to Dr. Davies, representing medicine, consists of Dr. J. C. Longfellow, Bellefontaine, dental member; Dr. John D. Porterfield, Columbus, public health member; Dr. James R. Hay, Columbus, veterinary member; and Miss Celia Cranz, Akron, nurse member.

Dr. Howard A. Rusk, chairman of the National Advisory Committee, in accepting Dr. Conard's resignation on behalf of the national committee, wrote Dr. Conard as follows:

CONARD PRAISED BY DR. RUSK

"Your resignation was presented to the National Committee at its meeting last week and special consideration was given to the length of service which you have rendered in World War II and at the present time—to the fact that you have certainly done more than what could have been called your share in connection with these military and civilian activities—and finally, in view of these factors your inalienable right to be relieved of these arduous duties at any time you so desire.

"The committee therefore accepts your resignation with regret and with deep appreciation for your complete cooperation and your unusually able management of these matters in the State of Ohio."

As chairman of the Ohio Advisory Committee, Dr. Davies will use the facilities and clerical staff of the Columbus Office of the Ohio State Medical Association. Although he will not serve on a full-time basis as did Dr. Conard, his home is in Columbus and he will be readily available for directing the work of the committee, handling correspondence, attending conferences, discussing matters over the telephone with interested physicians, etc.

COLUMBUS OFFICE TO BE USED

The mailing address of the Ohio Advisory Committee will be the same—1005 Hartman Theater Building, 79 East State Street, Columbus 15—and the telephone number will be the same—MAin 7715. Miss Elaine Fry of the Columbus Office staff has been assigned to the military affairs desk in charge of committee files and cor-

respondence, working under the direction of Dr. Davies.

For several weeks prior to this change, Dr. Davies was in close touch with Dr. Conard and the work of the committee, familiarizing himself with the regulations, procedures, correspondence and many problems which arise for committee action. For that reason, Dr. Davies did not in effect start at scratch but had the advantage of working with Dr. Conard before actually taking over the work of the chairmanship.

DAVIES WELL-QUALIFIED

Dr. Davies is a graduate of the Ohio State University College of Medicine in 1924; is a Fellow of the American College of Surgeons; in the active practice of surgery in Columbus; and a Captain, Medical Corps, U. S. Navy Reserve. He has had a long and distinguished service in the Navy. In addition, he is an experienced administrator and has been very active in the affairs of the Ohio State Medical Association for many years.

The Council of the State Association, in appointing Dr. Davies to the chairmanship of the Association's committee and recommending his appointment as chairman of the Ohio Advisory Committee to Selective Service, expressed the opinion that all parties concerned are fortunate in having been able to secure the services of Dr. Davies for these important responsibilities.

Announcement of the change in chairmanship has been sent to all members of the State Medical Advisory Committee, covering the 11 Councilor districts, and to the chairman of each of the County Medical Society advisory committees.

When he relinquished his duties, Dr. Conard expressed grateful appreciation to the state and local committeemen for their fine help and cooperation "without which the State Committee could not have operated," as he expressed it.

Dr. Ascher Receives Knapp Award For Aqueous Vein Research

Dr. C. K. W. Ascher, of Cincinnati, became the first Ohioan and the ninth person to receive the Knapp Medal of the Section on Ophthalmology of the American Medical Association.

The award was based on Dr. Ascher's paper on aqueous veins read before the Section on Ophthalmology at the 1952 annual session of the A.M.A. in Chicago, and was presented at this year's A.M.A. meeting in New York.

This high recognition of ophthalmologic research is given only for outstanding, exceptional and exhaustive contributions. Among former recipients are such outstanding physicians as Dr. Harvey Cushing and Dr. Frederick Verhoeff, of Boston.

Do You Know? . . .

Dr. Walter A. Reiling, Dayton, was elected president of Optimist International at the organization's annual convention in Washington, D. C. He has served successively as president of the Dayton unit, lieutenant governor and governor of the 24th District and last year as one of four vice-presidents.

* * *

Upon his retirement as head of the Department of Physiology, Western Reserve University School of Medicine, Dr. Carl J. Wiggers announced that he was joining the staff of the Cleveland Clinic Foundation where he will be associated with the Frank E. Bunts Educational Institute.

* * *

Dr. George T. Harding, Worthington, was elected president of the Ohio Citizens' Council for Health and Welfare at the annual meeting of the board of directors on June 19 in the Seneca Hotel, Columbus.

* * *

The following were initiated into membership in the Ohio Society of Pathologists at the May 23 meeting of the society in Cleveland: Drs. Lester Adelson, Harrison Latta, Harold Gold, Cleveland; James Dixon, Ashtabula; James McClellan, Lexington, Ky.; and Fred Dick, Jr., Columbus.

* * *

Of every 1,000 male employees 35 years old, 833 may expect to reach the normal retirement age of 65, according to a study by the Equitable Life Assurance Society. Developed as a pension guide, the study shows that men who become 65 in 1953 can expect to live another 14.8 years on an average.

* * *

Local members of the American Medical Women's Association in the Cincinnati area held a dinner meeting on May 20 at Our Lady of Mercy Hospital, Mariemont. Guest speaker was Miss Mary Maciel who spoke on "Labrador."

* * *

Richard Arthur McCormick, son of Dr. Edward J. McCormick, President of the American Medical Association, was ordained a priest in the Jesuit Order at West Baden College, West Baden, Ind., in June. The McCormick's have two other sons and three daughters.

* * *

Dr. Louis H. Hohman, recently of Indianapolis, Ind., has been appointed manager of the 200-bed Veterans Administration Hospital at Clarksburg, W. Va. A graduate of the University of Cincinnati College of Medicine, Dr. Hohman practiced in Cincinnati a number of years ago and later was at the V. A. Hospital in Dayton.

Medical Education Fund . . .

Medical Schools To Share in Over Three Million Dollars Contributed for Year by Medical Profession; 2,922 Ohio Physicians Make Contributions

OVER $3,000,000 was contributed for operating expenses of the nation's medical schools by 38,067 physicians during 1952, according to the second annual report of the American Medical Education Foundation issued July 11.

Of this amount, $2,250,000 was in unrestricted gifts directly to the medical schools by their alumni. Contributions to the A. M. E. F. amounted to $906,553, which included $500,000 from the American Medical Association; $113,232.64 from other societies and medical organizations and $291,478.68 from 7,259 individual physicians.

During 1951, contributions were made to the A. M. E. F. by 1,876 physicians, in amounts totalling $116,380. The 1952 figures represent an increase of 287 per cent in the number of contributors and an increase of 210 per cent in the total amount.

On July 1, a check for $1,044,602.47 was sent to the National Fund for Medical Education by the American Medical Education Foundation. This is the third such grant made by the A. M. E. F. during the last 30 months—a check for $640,682.90 was sent in 1951, and one for $777,019.41 in 1952.

The money is to be merged with that collected by the national fund and is to be distributed to the country's 79 medical schools for their unrestricted use.

The American Medical Foundation, sponsored by the A. M. A., began operation in 1951 to stimulate voluntary contributions from members of the medical profession for support of medical schools. The National Fund for Medical Education, located in New York City, is composed of men in business and industry, who solicit voluntary contributions from large corporations for the benefit of medical education in the United States.

The National Fund already has distributed $2,819,901 to medical schools, each four-year medical school receiving an average total of $37,500 and each two-year school an average total of $17,000.

OHIO CONTRIBUTIONS INCREASE

A total of 2,922 Ohio physicians made financial contributions to medical schools in 1952, according to the second annual report of the A. M. E. F. Of these, 1,657 contributed directly to their own medical schools, and 265 donated to the A. M. E. F. in amounts totalling $13,177. During 1951, a total of $5,735 was contributed to the A. M. E. F. by 152 Ohio physicians.

During the past year, the Woman's Auxiliary to the Ohio State Medical Association, under the chairmanship of Mrs. George W. Cooperrider, Columbus, raised $2,441 in behalf of the A. M. E. F.

Ohio's three medical schools each received a considerable sum from alumni during 1952. The University of Cincinnati College of Medicine Alumnal Fund raised $27,844 from 747 contributors. The Alumni Fund of Western Reserve University School of Medicine produced $25,953.11, with 537 contributors. Ohio State University College of Medicine is listed in the annual report of the A. M. E. F. as having received $19,056.96, from three contributors. The O. S. U. College of Medicine does not have its own Alumni Fund, though many O. S. U. medical alumni contribute to the Ohio State University Development Fund. If any such contributions are ear-marked for the medical school, proper credit will be given for them in the A. M. E. F. annual report.

"Only if our medical schools remain financially solvent can we hope to place medical education on a sound basis, free from the threat of government-sponsored plans or schemes to control it."—Dwight D. Eisenhower.

FALL CAMPAIGN PLANNED

Ohio's participation in the A. M. E. F. campaign for 1953 will be conducted in the Fall, under the direction of Dr. Wm. M. Skipp, Youngstown, working with the A. M. E. F. chairmen of the various county societies.

It is the hope of Dr. Skipp and his committeemen that Ohio physicians who have been supporting medical education, either by direct contributions to their own schools or to the A. M. E. F., will continue to do so—and that other physicians will realize the importance of keeping the nation's medical schools financially solvent under private auspices.

Minnesota Medical Association Celebrates 100th Year

The Minnesota State Medical Association is celebrating its 100th anniversary this year. In honor of the event, the *St. Paul Sunday Pioneer Press* published a special supplement on May 17, in which considerable historical data on Minnesota medicine are given.

General Practice Scientific Assembly . . .

Ohio Academy of General Practice Announces Third Annual Program To Be Held at Hotel Cleveland, September 16-17; Ladies Invited

THE Ohio Academy of General Practice has announced the complete program of its Third Annual Scientific Assembly to be held Wednesday and Thursday, September 16 and 17, at Hotel Cleveland, Cleveland. Officers of the Academy have invited all doctors of medicine to attend the well-balanced program.

WEDNESDAY, SEPT. 16

(Daylight Savings Time)

1:20- 1:50—"The Low Back Syndrome," Wallace S. Duncan, M. D., Cleveland, associate surgeon, Department of Orthopedic Surgery, St. Luke's Hospital; chief, Department of Orthopedic Surgery at Woman's Hospital, and at Doctor's Hospital; consultant in Orthopedic Surgery at the Glenville Hospital and the U. S. Marine Hospital.

1:55- 2:25—"Treatment of Hypertension," Irvine H. Page, M. D., Cleveland Clinic.

2:30- 3:00—"Time Honored Medical Procedures," C. Lee Graber, M. D., Cleveland, chief of staff and chief of surgery, Lakewood Hospital.

3:05- 3:35—"Diagnosis of Cancer of the Uterus," Robert L. Faulkner, M. D., associate professor of obstetrics and gynecology, Western Reserve University School of Medicine.

3:40- 4:10—"Importance of Treating Peptic Ulcer with Unlimited Diet," Edward A. Marshall, M. D., Cleveland, chief of Department of Huron Road Hospital.

4:15- 5:00—"Indications for Gastric Surgery," Richard R. Renner, M. D., chief of surgery, Doctors Hospital, and director of surgery, Doctors Clinic, Cleveland.

THURSDAY, SEPT. 17

(Daylight Savings Time)

9:00- 9:30—"Use and Abuse of Physical Medicine in General Practice," Harry T. Zankel, M. D., Cleveland, chief, physicial medicine rehabilitation, Crile V. A. Hospital.

9:35-10:05—"Some Recent Advances in Pediatrics," James G. Kramer, M. D., Akron, pediatrician to Akron Children's Hospital, Akron City Hospital, and Summit County Children's Home.

10:10-10:40—"A Newspaperman Views the Medical Profession," Mr. Don Dunham, Cleveland, medical writer for *The Cleveland Press.*

10:40-11:00—Recess.

11:05-11:35—"Pregnancy Accidents Associated with Alterations in the Hemostatic Mechanism," Duncan E. Reid, M. D., Boston, professor of obstetrics, Harvard Medical School, obstetrician-in-chief, Boston Lying-in Hospital.

11:40-12:10—"Spontaneous Hypoglycemia. Differential Diagnosis and Management," Jerome W. Conn, M. D., Ann Arbor, Mich., professor of internal medicine and director of endocrinology and metabolism, the Metabolic Research Laboratory, University of Michigan Medical School, Ann Arbor.

SPECIAL EVENTS

The Banquet will be held in the Grand Ballroom, Hotel Cleveland, on Wednesday, September 16, beginning at 7:00 p. m., with Dr. George W. Crile, Jr., as Banquet speaker. He will present an illustrated and entertaining talk and movie on "Treasure Hunting Holiday." Music, floor show and dancing will complete the evening until 1:00 a. m.

Entertainment has been arranged for the ladies for Wednesday as guests of the O. A. G. P. for noon luncheon, 12:30-2:30 at Higbee Company, Silver Grill, to be followed by a style show.

The Academy will mail during the summer to all Ohio doctors of medicine folders giving data on the program, registration, pre-registration and banquet tickets.

The House of Delegates of the Ohio Academy of General Practice will convene at 10:00 a. m., Tuesday, September 15, at Hotel Cleveland.

Dr. Southard Retires After 35 Years in Health Work

Dr. H. G. Southard, Marysville, former director of the Ohio Department of Health and for 35 years in public health work, has announced his retirement as director of the health district comprising Athens, Hocking and Vinton Counties.

A graduate of the Starling Medical College, Columbus, in 1906, Dr. Southard practiced in Marysville until 1918 when he entered public health work, serving with the U. S. Public Health Service for several years.

In 1924 he returned to Ohio and from 1931 to 1935 was State director of health. He has been successively health commissioner of Union County, the Hocking-Vinton district and finally the Tri-County district.

Succeeding Dr. Southard as district health commissioner is Dr. H. M. Boocks, Logan physician.

Medical Board Examinations . . .

A Total of 322 Applicants Apply for Licenses To Practice Medicine And Surgery in Ohio; List of June Examination Questions Are Given

THE State Medical Board gave examinations to 322 applicants to practice medicine and surgery in Ohio, June 15-17, Dr. H. M. Platter, Secretary, reported.

Results of the Examinations will be announced following meetings of the Board scheduled for August 24-25.

Sixty-five persons took the examinations to practice osteopathic medicine and surgery.

In the limited practice fields, examinations were given to the following: 49 chiropodists, 20 mechanotherapists, 45 chiropractors, 34 masseurs and 5 cosmetic therapists.

Following are the questions given to applicants to practice medicine and surgery:

ANATOMY

1. Name and give the origin of the various pelvic muscles inserted into the greater trochanter.
2. Describe, give attachments and relations of the duodenum.
3. Describe the Splanchnic nerves.
4. Which is more common, Colles fracture or dislocation of the wrist? Explain why.
5. In a radical operation for removal of the breast, what are the anatomical structures involved?
6. Describe the arterial supply and venous drainage of: (a) appendix; (b) The pancreas; (e)The ovary; (d) The thyroid.
7. Describe the blood supply to the brain.
8. Describe the Eustachian tube.
9. Describe the Brachial Plexus, giving its origin and distribution.
10. Give the development of the mastoid cells. What are the surgical risks in an operation for mastoiditis?

PHYSIOLOGY

1. State and explain the effect of a greatly diminished elasticity of the aorta and the large systemic arteries on (a) pulse pressure; (b) velocity of the arterial pulse, and; (c) character of the blood flow in the capillaries.
2. Describe the function of the gall bladder and its motor control.
3. Account for the loss of body weight that occurs during a period of exercise.
4. Describe and explain briefly the specific effects of (a) the incompetence of the aortic semilunar valves; (b) removal of the crystalline lens.
5. In the human being at rest, the output of the left ventricle is about 5 liters per minute. During vigorous muscular exercise, the output may attain 12-15 liters per minute. Account for this change.
6. Discuss the sources and energy for muscular contraction.
7. Is it necessary to determine the respiratory quotient in order to measure the basal metabolic rate? Give reasons for your answer.
8. Describe the movements of the stomach during the gastric phase of digestion of an ordinary meal.
9. Describe the auscultatory method of measuring systolic and diastolic arterial pressure in man. How would you determine mean arterial pressure in man?
10. Name three hormones that influence carbohydrate metabolism. Discuss briefly the physiological action of each.

BACTERIOLOGY

1. List a disease for which the following tests is the one of choice in diagnosis: (a) Precipitin test; (b) Agglutination test; (c) Complement fixation test.
2. What laboratory method would be of the most value in establishing the existence of the following: (a) Immunity to tetanus; (b) Undulant fever; (c) Influenza; (d) Meningitis; (e) Amebic dysentery.
3. List two infectious agents that are recovered best from: (a) the blood stream; (b) the stool; (c) the spinal fluid.
4. List the documents requiring the signature of a duly qualified physician which must be filed with a state or local agency.
5. Why is there an incubation period in malaria caused by plasmodium vivax following the bite of an infected mosquito?

DIAGNOSIS

1. A bookkeeper, male, single, thirty-five years of age, complains of attacks of tachycardia, flushing, excessive perspiration, and insomnia. The basal metabolic rate is plus 20. Physical examination reveals no evidence of cardiac abnormality other than the rapid heart rate. Discuss the differential diagnosis.
2. (a) Name the possible causes of recurrent syncope in a middle-aged male. (b) Outline the data elicited by history, physical examination, and laboratory study that are of value in the differential diagnosis of these possible causes.
3. Differentiate between anorexia nervosa and Simmond's disease (pituitary cachexia) with respect to diagnosis and prognosis.
4. What is the essential difference between thrombophlebitis and phlebothrombosis? Discuss the diagnosis and treatment of each.
5. A white male, forty years of age, entered the hospital with acutely painful, red, and swollen right wrist, left knee and left ankle joints. The onset was sudden, with involvement of the left ankle four days before admission. On the following day the left knee became involved, and on the day of admission, the right wrist. On admission the temperature was 102.4°F. and the white blood cell count 1400. What diseases must be considered as possible causes?
6. A woman fifty years of age gives a history of two severe gastrointestinal hemorrhages over a period of six months as indicated by hematemesis, tarry stools, and attacks of faintness. She enters the hospital with a third hemorrhage. State the possible causes and give the differential diagnosis.
7. What are the main types of chronic arthritis?
8. Discuss the factors that may predispose to the development of exogenous obesity.
9. List the causes of (a) purulent; (b) hemorrhagic; (c) fibrinous; (d) serous pericardial effusions.
10. Discuss etiology, diagnosis and prognosis of hypertrophic pyloric stenosis.

CHEMISTRY

1. Discuss factors involved in efforts to determine the functional efficiency of the liver, by chemical methods, or by laboratory procedures.
2. Describe the cephalin cholesterol flocculation test, and indications for its use.
3. Give the normal range of Serum amylase (diastase) and indicate the chief clinical value of Serum amylase determinations.
4. What is Bence Jones proteinuria? Thermalytic albuminuria?
5. Discuss the chemical nature and properties of the following: (a) acetone; (b) bilirubin.

MATERIA MEDICA AND THERAPEUTICS

1. Enumerate five conditions of modified drug action.
2. Give the administration and fate of salicylic compounds.
3. Give five contraindications to use of opiates.
4. Give nature of action and site of action: (a) epinephrine; (b) prostigmin; (c) atropine.
5. Draw a blood sugar curve giving the length of action of: (a) Regular insulin; (b) Globin insulin; (c) A mixture of 2 regular and 1 protamine insulin.
6. Outline the treatment of alcoholism.
7. Give the treatment of delayed, traumatic or oligemic shock.
8. Give the treatment of barbituate poisoning.
9. Outline the treatment of early syphilis.
10. Give the treatment of poisoning from local anaesthetic.

PRACTICE

1. Enumerate clinical types of dyspnea.
2. Give the etiology and manifestations of tularemia.
3. Give the etiology and clinical manifestations of ascariasis.
4. Give the manifestation and complications of influenza virus type B.
5. Give the manifestations and complications of moniliasis.
6. In what circumstances should the administration of electroshock therapy be considered?
7. Discuss the treatment of auricular fibrillation.

8. Discuss the treatment of chronic pulmonary emphysema.
9. Discuss the treatment of coarctation of the aorta.
10. Give the treatment of perinephritic abscess.

PATHOLOGY

1. List the pathological conditions in which excessive amounts of melanins are deposited in the skin.
2. List the lesions of the endocrine organs which may be present in pituitary basophilism (Cushing's disease).
3. Outline the pathogenesis of macrocytic anemia.
4. List the gross appearance of the organs in chronic lymphoid leukemia.
5. Outline the methods employed for the early diagnosis of carcinoma of the cervix of the uterus.
6. List 3 conditions under which metaplasia occurs.
7. What is the most common site of involvement in tuberculosis of the intestine?
8. List 4 rickettsial diseases of man and indicate the vector in each instance.
9. List the gross pathological changes in the mitral valve in a case of rheumatic endocarditis.
10. Name two conditions most frequently associated with thrombosis of the portal vein.

SURGERY

1. Describe the displacement of the proximal fragment in fracture of the shaft of the radius in (a) the upper third, (b) midshaft, (c) lower third. Describe the method of reduction and position of splinting at each site.
2. Enumerate, without discussion, the points in differential diagnosis in jaundice (a) due to hepatitis, (b) stone in common duct, (c) carcinoma at the papilla of vater.
3. Enumerate the causes of discharge of bright blood from the rectum. State in proper order the methods of examination used to reach a diagnosis in a case of rectal bleeding.
4. Should some, most or all patients with nontoxic nodular goitre be operated upon? Give the reasons for your answers.
5. Discuss early ambulation after abdominal operations.
6. What is penicillin? Give the indications and contraindications for its use in surgery.
7. Discuss pyloric stenosis in infancy.
8. Discuss the indications for drainage after appendectomy.
9. What principles underlie the treatment of gunshot wounds of the abdomen? Omit operative technic.
10. Discuss the prevention of reactions following blood transfusions.

OBSTETRICS AND GYNECOLOGY

1. When would a diagnosis of dysfunctional uterine bleeding be warranted?
2. When is surgery indicated in the treatment of cancer of (a) the corpus; (b) the cervix uteri?
3. Give the differential diagnosis between endometriosis and pelvic inflammatory disease.
4. Discuss the advantages and disadvantages of (a) breast nursing; (b) "rooming in" of baby with mother.
5. Enumerate five gynecologic conditions that require prompt and surgical procedure and state the reasons why.
6. Describe the subjective and objective phenomena of a normal climacteric.
7. Describe the management of the 3rd stage of labor; (b) What are the chief dangers in this period?
8. What factors should be investigated in a woman who after two years of effort, fails to become pregnant?
9. & 10. True or False?
   (a) A Willit forceps is used in a breech delivery on the aftercoming head.
   (b) Painless vaginal bleeding in between the menstrual periods might be due to a chorio-epithelioma.
   (c) A persistently positive Friedman test after complete evacuation of a hydatidiform mole is an indication for hysterectomy.
   (d) Dyspareunia usually produces a fever and leukocytosis?
   (e) Endometrial biopsy is of no value in the determination of ovulation.
   (f) Erythroblastosis in a fetus is the result of conception of an Rh positive woman by an Rh negative man.
   (g) An anthropoid pelvis is frequently associated with mid pelvis and outlet contraction.
   (h) Anovulatory menstruation can be produced by the administration of estrogens in normally menstruating women.
   (i) Painless uterine hemorrhage during the last month of pregnancy is due to abruptio placentae.
   (j) Uterosalpingography is the breaking up or freeing adhesions between the uterus and tubes.

Legislative Session Over; No Bad Medical-Health Bills Enacted

The 100th Ohio General Assembly has closed up shop.

During the more than seven-months' session approximately 80 bills having some bearing on medical or health activities were followed by representatives of the Ohio State Medical Association. No bills opposed by the Association were enacted; some which were supported by the Association were acted upon favorably.

A digest of the work of the General Assembly with regard to medical and health legislation will be published in an early issue of *The Journal*.

During the session the State Legislative Committee and Columbus Office Staff received excellent help and cooperation from the Legislative Chairmen and Officers of most of the County Medical Societies and from certain key physicians who were called on for work "back home" when the going got tough. This proved once again that the medical profession can make its influence felt on legislative matters if real work is done by the County Society officials in their own communities at the right time.

SPECIALTIES

1. Give the differential diagnosis between dermatitis venenata, dermatitis medicamentosa and urticaria.
2. A married man, 38 years of age, presents himself with a raised, reddened infected papule on his upper lip. What procedure would you follow?
3. Describe the chief functions of the nose.
4. Discuss the causes of finding pus in the urine and their treatment.
5. True or False?
   (a) The canal of Schlemm empties under the middle turbinate bone of the nose.
   (b) Stenson's plexus is adjacent to the rods and cones.
   (c) The nose is lined with ciliated columnar epithelial cells.
   (d) Repeated ear infections are cause for tonsillectomy.
   (e) The nasal vein empties into the angular vein which in turn empties into the superior ophthalmic vein.

PREVENTIVE MEDICINE AND HYGIENE

1. Discuss vaccination, for example, against smallpox, and immunization, for example, against diphtheria, as to usual methods employed and reaction or process within the body producing immunity to the disease.
2. Name five diseases that may be transmitted from animals to man. Tell if there is a vaccine for each and tell how each may be prevented.
3. Describe and tell what should be done to prevent surgical shock.
4. Give cause, means of prevention and outline the public health responsibility of the physician in ophthalmia neonatorum.
5. What is the cause, source, means of communication and proper procedure to prevent Salmonella infection?

McCormick's Nationwide Address . . .

President of the American Medical Association Tells Profession's Story to Public over 330 Radio Stations Throughout the Country

OHIO physicians will be interested in reading the address given by Dr. Edward J. McCormick, Toledo, President of the American Medical Association, at a special inauguration session of the A. M. A. House of Delegates and the membership at large on June 2 in New York. Appropriately entitled, "American Medicine's Report to the Nation," the speech was recorded by the ABC Network and broadcast nationwide over 330 affiliate stations.

* * *

In reaching the successive milestones of life, men reckon their progress in different ways. Some put ahead of everything else their achievements in business or professional activities. Others value most the blessings of home and family. Still others weigh strongest their accomplishments in terms of benefit to mankind. But no matter how the reckoning is done, it is my belief that humbleness and abiding faith in God should be the common denominators. It is in this spirit that I approach the position of honor assigned me by my colleagues in the medical profession.

High office, whether it be in government or in private life, carries with it certain basic obligations. These obligations are not only to those who elect you. The exercise of official duty should extend beyond the narrow confines of selfish interest and should be dedicated to the public good. In serving the American Medical Association as president for the coming year, I shall be representing an organization that has a long and honorable history of service in the public interest.

In taking the solemn oath of office tonight, I pledged myself to carry on this tradition of public service. To succeed I will need your wholehearted cooperation and the divine guidance of God, for which I pray.

MEDICINE'S GOLDEN ERA

This evening I should like to present American Medicine's Report to the Nation. In a golden era of tremendous medical advances, which has already brought the elimination or control of many deadly diseases and the development of surgical techniques that once were undreamed of, the past year stands out as one of exceptional progress in medical science.

What parent did not thrill at the news that trials involving 55,000 children in polio-plagued communities showed gamma globulin from human blood could at least temporarily prevent the onset of the dreaded paralytic type of polio? And soon after came the electrifying announcement that doctors were in the process of developing a successful vaccine against all three of the known polio viruses. Many months of cautious and painstaking experimentation are still required before the vaccine can be made available for general distribution, but the reports published are most heartening. Because of production difficulties gamma globulin will be given limited distribution through the Office of Defense Mobilization for some time to come. However, it will be made available wherever drastic, emergency preventive measures are indicated.

A moment ago I made passing mention of great strides in surgical techniques. This fact was brought home in dramatic fashion last December at the University of Illinois medical school in Chicago. With literally the attention of the world focussed on the surgical amphitheater at the University, a highly-skilled team separated the 15-month-old Brodie Siamese twins who had been joined at the head. Only twice before in medical history had separation of Siamese twins of the cranium been attempted, and in both cases the twins died before the separation was completed. Today one of the Brodie twins is alive and apparently destined to lead a relatively normal life.

UNLIMITED HORIZONS

Operations upon the heart, the brain, the lungs and stomach and other vital organs, impossible 25 years ago, are now being accomplished with safety and success. Advances in orthopedic surgery have brought happiness and independence to many who were crippled and the light of hope is seen in the darkness of cerebral palsy. Patients walk about the wards of our great hospitals the day of major surgery and are discharged in a week. Surgery and radiology are producing an increasing number of cures in cancer cases.

More men and women will live and work long after 65 years of life in the immediate future. Today we find it necessary to review our estimates and definitions of old age and human usefulness.

The horizons of medicine are unlimited! Research workers are making magnificent progress in all fields. Spectacular devices such as the

mechanical heart and lung and the mechanical kidney demonstrate man's ability to ferret out the long hidden secrets of the human body. I can predict with confidence that the doctor of the future will do much of his work in the field of disease prevention.

ACCIDENTS—BLIGHT ON PROGRESS

Unfortunately there is one disease for which we can never hope to develop a vaccine, and that is preventable accidents. Last year alone, according to the National Safety Council, 96,000 Americans died as the result of accidents of all types. In the same period, one out of every 16 persons in the United States suffered a disabling injury, or a total of 9,700,000—roughly the combined population of metropolitan New York. A population approximately the size of Atlanta, Georgia—350,000 persons—was left permanently disabled by injuries.

Aside from the pain and mental anguish, the cost of these accidents amounted to $8,300,000,000 in medical expense, overhead costs of insurance, property damage and lost wages. The accident problem must be solved, for accidents—preventable accidents—are a waste of money, time and medical talent which could be more effectively utilized in the prevention and elimination of disease.

ORGANIZED MEDICINE GROWS

Much of the progress of medical science in this country coincides with the growth of organized medicine. One hundred and six years ago, scattered medical societies throughout the nation joined hands to form the American Medical Association, thereby setting up a democratic procedure for elevating the standards of the medical profession on a uniform basis. Today the Association is composed of 140,000 doctors who express the medical needs of their respective communities through the representatives they elect to the A. M. A.'s House of Delegates. They spend $10,000,000 each year studying and working in the fields of rural health, industrial health, the availability of physicians, medical care for the armed forces, civil defense, medical education, hospitals, nursing, mental diseases, health education, exposing quacks and fakers and searching for ways to help the chronically ill and those who have trouble paying for medical care. These are only a few of the A. M. A. activities.

HEALTH INSURANCE

We have encouraged the development of voluntary prepaid health insurance plans to assist the individual and family in meeting the unexpected costs of sickness. Such plans are being constantly improved to include protection against long-term, disabling illness or injury and to provide coverage without regard to age. The growth of prepaid medical and hospital expense coverage is unparalleled by comparison with any of the spectacular advances made in the history of insurance. There are more than 90,000,000 Americans now carrying hospital, surgical and medical insurance. Add to this total the people covered by industrial insurance, veterans' benefits and local, state and federal custodial programs as well as those cared for in the great charity hospitals throughout the country and we are justified in questioning the motives of those who would place all of our sick under government dictation.

Recent figures gathered for the Federal Reserve Board by the Survey Research Center of the University of Michigan indicate that 80 per cent of American families have no medical debt at all. Seventeen per cent have medical debts of one dollar to $200, an amount that could normally be met without too much difficulty. Only three per cent had medical obligations in excess of $200.

PROFESSION CLEANS HOUSE

Doctors have been criticized by many. We make no claim to sainthood. We have in our midst a certain number, perhaps three to five per cent, who are not worthy members of an honorable profession. We have established mediation committees in all forty-eight states to hear patient complaints and try to work out a solution. Here and now I call upon all county medical societies to continue to expel from our ranks those who are unethical, dishonest and unfair. We cannot protect or condone the few who bring disgrace upon us. We owe to the American people protection from the small number of greedy and godless physicians who flagrantly violate the noble traditions of the medical profession. But let us do this job in an orderly fashion, making speedy, effective use of the disciplinary machinery already available in our medical societies. By eliminating the wrongdoers in this way we will restore the public faith in the 95 per cent of ethical practitioners whose reputations have been tarnished by irresponsible, generalized accusations.

PHYSICIAN SUPPLY INCREASING

We are making great progress in the expansion and building of medical schools, which is steadily increasing the supply of physicians. Since 1929 the supply of doctors has been increasing consistently faster than the growth of our national population. In the past 10 years the number of graduates from medical schools increased more than 19 per cent. There is every indication that there will be an additional increase of 25 per cent in the number of medical graduates during the next 10 years.

Plans are now well underway for the establishment of several new medical schools. In only

the last three years, nearly $242,000,000 was spent for new construction to expand medical school facilities in the United States. The American Medical Association always has, and will continue to encourage sound expansion of medical schools and their educational programs. Last year more than $3,000,000 was given by 37,000 doctors in direct support of medical education. If contributions to building funds and for other special purposes were included these figures would be even larger. A substantial portion was raised through the American Medical Education Foundation and the National Fund for Medical Education. I appeal to all doctors and business and industry to support these two fund-raising organizations as a means of eliminating federal subsidy of medical education with its potential threat of ultimate socialization. The trend is away from centralized government domination. As Americans, let us keep it that way by supporting and promoting all voluntary, private activities at the national, state and local levels.

DOCTORS PLACED IN RURAL AREAS

Today with one doctor for every 730 persons, the United States has more physicians than any other country in the world. Those who have carefully studied complaints of physician shortages have come to the conclusion that shortages are caused not by a nationwide lack of doctors, but primarily by faulty distribution due to professional factors related to their practice. They feel they cannot practice the kind of medicine they want to without modern equipment. Since they cannot finance such equipment in their early years of practice, they tend to settle in metropolitan areas where up-to-date facilities are readily available. To help resolve this serious problem, physician placement services have been put in operation by medical societies in most states. Strongly supported by the American Medical Association, these placement services are helping to assure an equitable distribution of doctors throughout the nation. Under this plan, many rural communities are building offices or small hospitals and equipping them with modern medical apparatus as inducements for young doctors. In Kansas, for example, this procedure attracted 67 new doctors to communities of 2,500 or less persons in a period of only two years. Many of these communities had not had a doctor for years.

We have been and will continue to be concerned when patients tell us they have difficulty in reaching a doctor in an emergency or during night hours. In 1948 there were only 60 night and emergency telephone centers sponsored by county medical societies. Last year this total had grown to 650. And these centers are continuing to increase. Every medical society in the country should initiate and finance this type of service.

FEES AND THE FAMILY DOCTOR

Likewise, every family should select for itself a family physician in whom it has confidence and whose advice will be followed in emergencies and when seeking the services of specialists. In establishing this family-physician relationship there should be no hesitancy in discussing fees. Every individual should feel perfectly justified in requesting a frank discussion of fees with his doctor. Mutual understanding of the economics of medical care is most important, and I would like to encourage both patient and physician to develop such an understanding.

I have told you tonight of some of our activities in public service to the nation and of the great progress made in American medicine. Time will not permit a more detailed description of our activities, but these are a matter of record available for the perusal of all.

CONTINUED FIGHT FOR PROGRESS

We shall continue to support all programs for the good of the public health, as we have done over the years. With but one exception there has been no major federal health law enacted that was not sponsored or supported by the American Medical Association. And the one exception turned out to be such a failure that Congress refused to renew the act when it expired.

We shall fight with all of our strength matters that are not in the public interest. The American Medical Association throughout its history has been a champion of sound progress in medicine. It has had to fight many battles against quackery, against political interference and against slipshod medical training and practice. An organization cannot be a strong, fearless leader without creating bitter enemies and staunch supporters. We have both today.

If anyone can present a plan of medical care or a way of life that is an improvement on the American way, we shall listen with attentive ear. But we will not compromise American freedom and ideals. Nor are we disposed to support anything but the best in medicine. In our care is the health of the American people. Its improvement is our sole and constant goal. We shall be true to this trust.

Annual Hospital Survey . . .

Ohio Shows Marked Increase in Number of Hospitals and in Services According to A.M.A. Report; Hospital Births Are at All-Time High

APPROVED hospital facilities in Ohio showed considerable increase in every respect during 1952 compared to the previous year, according to the annual report of the Council on Medical Education and Hospitals of the American Medical Association.

Although Ohio's increases were considerably ahead of those of the nation percentagewise, there was a general increase in services throughout the Nation. The 6,665 registered hospitals in the country reported a bed capacity of 1,541,615, and a total of 18,914,847 admissions.

Ohio was well ahead of the 1951 all-time record in number of births in hospitals with 188,326, compared to 178,122 the previous year.

The Nation also had a record of babies born in hospitals, for the first time going over the three million mark. The total born in hospitals was 3,170,495.

Ohio was well ahead of the Nation in percentage of births in hospitals. The figure given for the Nation is 80 per cent of the estimated 3,910,000 births in the United States during 1952. In Ohio 91 per cent of the total of 206,779 live births were in hospitals.

In less than 25 years, the nation's hospital birth rate has increased five fold.

TYPES OF SERVICES

The increasing problems of mental health were highlighted in the present report. Although there are only 585 psychiatric hospitals, they have a greater bed capacity—732,929—than is found in any other group. Again the average daily census of patients in the psychiatric hospitals is the highest that has been recorded in this field. The daily census in mental hospitals of 704,056 represents 53.7 per cent of the daily patient load in all registered hospitals.

A total of 688,119 mental patients were under daily care in governmental institutions (Federal, state, county and city), while only 15,937 were in nongovernmental hospitals. Even though only 1.6 per cent of the total number of patients admitted to all hospitals during 1952 were mental patients, mental hospitals maintained an average daily census greater than the total patient load in all other registered hospitals. This is indicative of the long period of hospitalization required by such patients, the report stated.

Of the hospitals currently registered by the A. M. A., 2,078, or 31.1 per cent, operate under governmental auspices, whereas 4,587, or 68.8 per cent are in the nongovernmental group.

General hospitals, totaling 4,924, represent 73.8 per cent of all hospitals registered. They have a total bed capacity of 640,923, and rendered the greatest volume of service in the hospital field by admitting 17,760,057 patients and reporting 3,090,807 births. Tuberculosis sanatoriums numbered 428, with an 89,571 bed capacity.

Governmental hospitals, with 71.3 per cent of the hospital beds, received 26.3 per cent of the patients admitted during 1952, while nongovernmental hospitals, representing 28.6 per cent of the present bed capacity, can be credited with 73.7 per cent of all patients accepted for hospital care. This difference is a reflection of the hospitalization required by psychiatric patients, the majority of whom are cared for in governmental institutions, the report states.

The average length of stay per patient in governmental general hospitals was more than twice that per patient in nongovernmental institutions. The average stay in governmental general hospitals was 16.4 days, as contrasted to 7.5 days in nongovernmental general hospitals. In 1951, the average stay was 17.0 days in governmental institutions and 7.7 days in nongovernmental.

OHIO HOSPITALS BY TYPE

Following are the number of approved hospitals in Ohio and the number of beds by type of service offered: General, 158 with 27,497 beds; nervous and mental, 29 with 36,997 beds; tuberculosis, 24 with 4,603 beds; maternity, 9 with 250 beds; industrial, 1 with 18 beds; eye, ear, nose and throat, 1 with 6 beds; children's, 4 with 571 beds; orthopedic, 3 with 180 beds; convalescent, 8 with 341 beds; hospital departments of institutions, 10 with 669 beds; all other, 4 with 1,212 beds; total 251 with 72,344 beds.

NURSING

The report gave the following information in regard to nursing personnel and schools of nursing in Ohio: Student nurses, 5,873; accredited schools of nursing, 58; schools offering affiliated courses only, 15 with 767 students; administrative nursing personnel, 446, full-time instructors, 409; supervisors and assistant supervisors, 1,044; head nurses and assistant head nurses, 1,667; general duty nurses full time, 5,296; general duty nurses part time, 2,493; nurses not classified, 322; total graduate nurses, 11,677; private duty nurses, 1,457.

The following information was given on practical nurses and auxiliary personnel in Ohio:

APPROVED HOSPITAL FACILITIES IN OHIO DURING 1952

Control	No. of Hospitals	Beds	Bassinets	Patients Admitted	Average Census
Federal	7	5,345	22	26,373	4,560
State	29	36,314	56	28,348	33,694
County	32	5,214	250	40,622	4,294
City	15	2,987	380	69,291	2,179
City-County	3	156	49	6,957	107
Total Governmental	86	50,016	757	171,591	44,834
Church Related (Nonprofit)	51	9,712	1,689	354,037	8,049
Nonprofit Associations	95	11,634	1,950	416,328	9,080
Total Nonprofit	146	21,346	3,639	770,365	17,129
Individual and Partnership	9	275	7	1,686	215
Corporations (Profit Unrestricted)	10	707	20	7,641	692
Total Proprietary	19	982	27	9,327	807
Total Nongovernmental	165	22,328	3,666	779,692	17,936
Grand Total	251	72,344	4,423	951,283	62,770

Schools of practical nursing, 10; practical nurse students, 207; practical nurses employed, 1,180; attendants, 5,733; nurses' aides, 7,612; ward maids, 1,646; orderlies, 956.

The following information was given on technical personnel in Ohio hospitals: Medical technologists full time 1,006, part time 172; x-ray technicians full time 520, part time 90; physical therapists full time 151, part time 14; occupational therapists full time 147, part time 17; medical record librarians full time 254, part time 26; other medical record personnel full time 474, part time 77.

Central Ohio Heart Association Assigns Research Grants

The Central Ohio Heart Association, 30 East Broad Street, Columbus, has allocated $44,821.55 for local research into the causes and treatment of heart disease and $11,800.00 in fellowships in cardiology. Funds for these grants were collected from 51 counties in Ohio.

Work on these projects will be conducted at Ohio State University in the Departments of Physiology, Medicine and Pathology, University Hospital Heart Station, Ohio State Tuberculosis Hospital, Marion City Hospital, Frederick C. Smith Clinic of Marion and Children's Hospital, Columbus.

Investigators and institutions at which they will work are as follows: Ohio State University—Drs. Eric Ogden, R. W. Kissane, Leo Sapirstein, R. W. Stacy, E. von Haam, J. M. B. Bloodworth, George Shinowara, A. Towbin, Clifford Angerer and Nancy M. Buckley, and Messrs. Arthur Eberstein and Albert T. Kornfeld; University Hospital, Columbus—Drs. J. M. Ryan, J. F. Schieve, H. B. Hull, R. L. Wall; Ohio Tuberculosis Hospital, Columbus—Dr. R. J. Atwell; Children's Hospital, Columbus—Drs. Warren Wheeler and Oliver Hosterman; Marion City Hospital—Dr. William B. Leffler; Frederick C. Smith Clinic, Marion—Drs. Philip W. Smith, Hugh A. Cregg, Charles W. Wilson.

McCormick Lauded By Ohio House of Representatives

By a unanimous vote, the House of Representatives of the 100th Ohio General Assembly on July 9 adopted a resolution (H.R. 193) congratulating Dr. Edward J. McCormick, Toledo, upon his inauguration as president of the American Medical Association. The resolution read as follows:

Whereas, the members of the House of Representatives of the 100th General Assembly note with particular pride the news of the elevation of an Ohio surgeon, Dr. Edward J. McCormick, of Toledo, Ohio, to the Presidency of the American Medical Association; and

Whereas, Dr. McCormick is a Past-President of the Ohio Medical Association and has served in numerous other official capacities from the local to the national level; and

Whereas, in 1949, Dr. McCormick was a member of the medical mission invited by General Douglas MacArthur to make a survey of Japan's health needs, and the following year he went to Geneva as a United States delegate to the third assembly of the United Nation's World Health Organization; therefore be it

Resolved, That in tribute and respect to an outstanding Ohioan who through the forces of industry, ability, and leadership has attained one of the highest honors his profession can bestow upon him, this Resolution be adopted and a copy thereof be spread upon the Journal; and be it further

Resolved, That the Clerk of the House of Representatives transmit a properly authenticated copy of this Resolution to Dr. Edward J. McCormick.

Radiological Society Elects Officers

At the annual meeting of the Ohio State Radiological Society, held at the Van Cleve Hotel, Dayton, May 23-24, the following officers were elected; Dr. Austin J. Brogan, Dayton, president; Dr. Willis S. Peck, Toledo, vice-president; Dr. M. M. Thompson, Jr., Toledo, secretary-treasurer. Dr. John Hannan, Cleveland, was elected member at large.

Hospital-Physician Relationships . . .

A.M.A. Board of Trustees Approves Statement Formulated by Its Joint Committee with A.H.A. After Considerable Study on Subject

IN 1951 the Board of Trustees of the American Medical Association appointed a committee to meet with representatives of the Board of Trustees of the American Hospital Association for a discussion of matters of mutual interest. Several meetings subsequently were held by representatives of the two organizations. At a final session on March 21, 1953, a statement on the question of hospital-physician relationships was prepared and approved by representatives of the two groups. This statement was approved also by the Board of Trustees of the A. M. A. and was submitted at the New York meeting to the House of Delegates, which approved it.

The complete statement follows:

* * *

Physicians and hospitals are both concerned with rendering medical care. Their first consideration is their desire to promote the welfare of the patient and the community which they serve. Physicians are the individuals who provide medical care—whether it be in the home, the office, or the hospital. With the ever-increasing complexity of modern medical care, however, the role of the hospital in providing an organization and an environment in which the physician may care for patients is assuming increasing importance.

Problems associated with the evaluation of services by hospitals and by physicians are different. It is possible to develop minimum standards in a hospital by which the adequacy, type and quality of hospital service may be measured and compared, and the cost per unit of service determined.

It is much more difficult to evaluate the service of a physician. Specialty boards have done much to improve the quality of service. Although a specialty board may find that an individual has had good training and that he is capable of carrying out certain procedures, it cannot know what is in his heart and soul, his sense of obligation or degree of devotion to his duty.

A MORE INDIVIDUAL TOUCH

With the increase in size and complexity, care rendered in hospitals tends to become less personal. In an effort to overcome this, hospitals have striven to indoctrinate all associated with them in the desirability of developing a more individual touch.

Medicine, on the other hand, by its very nature, is more personal. It is both a healing art and a science. These two cannot be divorced without grave injury to medicine and to quality of care received by patients both within and without the hospital.

TECHNICAL PROCEDURES ECLIPSE ART

With the rapid advance of the science of medicine in the past fifty years, the importance of the art has been lost sight of by many. The tendency to put faith in the physical attributes of medicine—building, equipment and technicians—has developed to an increasing degree a mechanistic rather than an intellectual and spiritual approach to medicine and its problems.

One evidence of this has been an overuse of and overdependence upon technical procedures in hospitals at the penalty of increased operating costs and possible deterioration in the quality of performance of these technical procedures. This fault does not lie alone at the door of hospitals since physicians are responsible for the number and type of procedures ordered.

It is, however, the result of our present operating procedures, and illustrates the failure to integrate adequately the administrative and professional aspects of the hospitals.

NEEDS COORDINATED EFFORTS

On the other hand, the idea that a hospital should be merely a physician's workshop and supply the facilities and tools to allow him to work unhampered by restrictions is untenable. These tools are too numerous, too unwieldy and too expensive. Their use needs the coordinated efforts of many individuals—nurses, dietitians, technicians of all kinds—as well as those of a physician or physicians.

Their proper use still requires the fine discrimination in their selection and application that only a physician can supply.

ADMINISTRATION

The administrator, under the direction of a governing board, has the primary responsibility of running a good hospital in which good medical care is provided. He is concerned with costs, personnel, housekeeping, maintenance, and expansion of facilities, as well as with the medical care provided in the institution. It is his responsibility to coordinate into a smooth running whole the multiple activities of his institution. He looks to the board on the one hand and to the professional staff on the other.

Due to the nature of his position and his responsibilities, he looks more directly to the

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22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8	·	6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[5]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	*1443*	*968*	*1380*	*17*	*8*	*38*	*1142*	*132*	*131*	*12*	*26*	*54*	*552*	*52*	*179*	*634*
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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board. His worth, however, must be evaluated finally on the basis of how well he maintains a good hospital within available resources.

POSITION OF BOARDS

The governing boards of hospitals are usually made up of men and women of demonstrated ability occupying positions of prominence and who have evinced interest in community welfare. These individuals add strength to the hospitals by their names, general knowledge of affairs, money-raising power and prestige.

They are not necessarily particularly informed as to the many intricate problems involved in the production of good medical care. While there are many who go deeply into the problem of hospital finances and management, few of them ever have the opportunity to make themselves familiar with the problems of medicine. The very nature of their assignment continues this segregation of thought.

The board has frequent and often intimate contacts with the administrator and little or none with the professional staff or its representatives. If they have opinions on medical matters, they are likely to be gained from their personal medical advisor or by casual contacts at social gatherings or on the golf course.

It follows, therefore, through no fault of his own, that the administrator may have undue influence with the board in professional matters as well as those that properly come within his province.

MISUNDERSTANDINGS

Misunderstandings between hospital management and the medical profession arise from fears concerning each other. Some of these are reasonable and some are unreasonable. Some arise from conflicts of personality in particular institutions. These differences have been aggravated by certain general trends and by proposals coming from within and without the ranks of those providing medical care.

A physician desires to maintain and strengthen the art of medicine as well as promote the greatest possible advance in the science of medicine. He sees medicine more and more mechanized and coming more and more under the direction of administrators and boards in hospitals.

The administrator and the board are concerned not only with the over-all quality and quantity of service rendered by hospitals but also with the financial integrity of their institution. Certain of the factors involved in the production of good medical service come directly and properly under their control. They may be disturbed, however, by dissension in the professional staff, by clique or favoritism, or by failure of the staff to maintain a high quality of professional service. Hence, they may be tempted to interfere with professional control or professional practice.

It should be noted that in the past professional standards have been raised substantially through the influence of professional groups and by the action of special committees of the professional staffs of individual hospitals. It would seem unnecessary to state that in a learned and highly technical profession the true qualifications of a member can only be judged by other members of the same profession.

The administrator and the board are also troubled at times by the multiple and unreasonable demands made on them by the professional staff. This often arises from lack of understanding on the part of the staff members of the total responsibility of the administrator and the total load on the resources of the hospital.

SELF-GOVERNMENT OF STAFF

It is a basic principle that hospital governing boards and administrators should not attempt to tell physicians how to practice medicine but rather must see that the hospital medical staff organizes to provide a framework for staff self-government which will maintain and improve the quality of medical care in the hospital.

Physicians, upon their part, must understand that the hospital governing board is legally and morally responsible for the entire operation of the hospital. The medical staff is responsible to the governing board for proper medical care in the hospital.

The medical profession has provided leadership in improving the quality of care in hospitals. Such efforts, however, do not always receive the support of every member of the hospital medical staff. The authority of the hospital governing board and administrator may be used to enforce rules not complied with by individual members of the staff, although the rules have been developed and approved by vote of the organized medical staff. This authority of the hospital governing board and administrator, when in proper focus, has been an important force in improving the quality of care in the hospitals of this country.

Lack of understanding and appreciation of these important relationships has caused much criticism and irritation between the members of the hospital governing board, the medical staff and the administrator.

FULL-TIME PROFESSIONAL PERSONNEL

A continued increase in the utilization by hospitals of full-time professional men has disturbed many physicians. In the early days of radiology and pathology, this did not seem a threat to the profession. With the great increase in these services and the advent of anesthesiology, physical medicine, cardiology, and other specialties, this

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threat and the possibility of friction has increased.

The practice in certain hospitals of engaging full-time obstetricians, surgeons and other specialists has stirred this alarm further.

The trend toward a situation, however, where hospitals with a complete full-time staff are engaged in the practice of medicine for a fee, is a matter of concern to many physicians. The profession justly feels that it may lose its independence and become merely a group of high grade technicians, however respected or highly paid.

There are many who believe that a group of physicians working full time, under a lay board, will not produce the best of medical care. There are, however, those in the profession who support the principle of "full time" as a means of providing good medical care in a hospital.

DIVISION OF RESPONSIBILITY

Recognizing the intimate relationship and mutual problems, it follows, then, that there must be a clear and well-defined division of responsibility between the professional staff and the governing board of the hospital. Since they are mutually dependent upon each other in providing good care in the hospital, they should be mutually assured by methods of organization that neither can encroach upon the proper domain of the other.

If all board members, administrators and physicians were saints, possessed of infallible judgment, perfect in their training and beyond reproach in their actions, there would be no problem. Since these assumptions are not true, it is necessary to adjust their relationship on a basis that will maintain the prerogatives of each.

To accomplish cooperation and understanding, there must be a free flow of information and ideas between the professional staff, the administrative head and the governing board. Each must accept the primacy of the other in certain fields and all must recognize their interdependence in accomplishing their primary objective.

Physicians must become familiar with problems of hospital administration and financing. If they do, they will be more understanding and cooperative in conserving the hospital resources and less demanding in their own requirements. They will also be a much more effective instrument in gaining for a hospital community support for its proper operation.

RECOMMENDED PRINCIPLES

In order to accomplish these objectives, some mechanism must be set up that will bring into frequent and close contact the partners in the hospital endeavor, the administrator, the governing board and the professional staff. It is also necessary that the relationship between physicians and hospitals be clearly defined and, as a guide toward this aim the following principles are recommended:

1. The general purpose of hospitals and physicians is to aid each other in the delivery of the best possible medical care to patients. To attain such a purpose requires full cooperation among medical staffs, governing boards and administrative heads of hospitals. One important method of attaining this objective is that duly designated representatives of the medical staff shall have free and direct access to the governing board with due consideration to the position of the administrator as chief executive officer of the hospital. The various methods by which the medical staff may have access to the hospital governing board follow. These methods are not listed in the order of their desirability, and there may be other acceptable liaison plans developed depending upon local conditions.

   a. The executive committee of the medical staff and a committee of the governing board with the hospital administrator can serve as a joint committee.

   b. Representatives of the medical staff can serve as members of the medical staff committee of the governing board with the hospital administrator.

   c. Representatives elected by the medical staff can attend meetings of the hospital governing board.

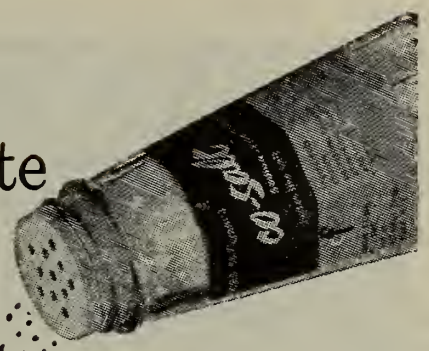
   d. Members of the medical staff can be members of the hospital governing board.

2. The professional evaluation of chiefs of services and members of the medical staff should be the responsibility of the medical profession. The method of selection of these individuals must be subject to local arrangement and local conditions. In any such arrangement, however, the principle of the freedom of the staff to make recommendations, subject to the approval of the hospital governing board, should be recognized.

3. The medical profession and the hospitals recognize that certain special services, such as, anesthesiology, pathology, radiology, and physical medicine are integral parts of the practice of medicine and of the services necessary for hospital patients. Physicians in these fields should have the professional status of other members of the medical staff. Chiefs in these specialties must assume also the administrative responsibilities and relationships customarily associated with such positions.

4. The right of an individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure (a) the policy of professional incentive for the physician, and (b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be

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rendered. Moreover, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organization, group, or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the patient, the hospital, or the physician.

5. The chief of a hospital department may have access to financial information regarding his department.

6. It is desirable that means should be provided at local, state and national levels for review of problems of individual hospital-physician relationship by organized medical and hospital groups.

Pharmacist Briefs Regulation Changes By Durham-Humphrey Act

High lights of regulations on refilling of prescriptions under the Durham-Humphrey amendment to the Federal Food, Drug and Cosmetic Act are outlined for physicians in the following article. The article, written by Robert A. Hardt, of the American Pharmaceutical Manufacturers' Association, was in the form of a letter to the *Journal of the American Medical Association.* The article follows:

* * *

Your readers will be interested in the recently enacted Durham-Humphrey Bill because it has changed the regulations on the filling of prescriptions and the labeling of pharmaceutical products. The following aspects of the Durham-Humphrey Acts are of special significance:

1. **Telephone prescriptions.** As in the past, the Durham-Humphrey Act permits the physician to telephone prescriptions to the pharmacist; however, the pharmacist is now obliged to write down such prescriptions immediately, and he must record them.

2. **Refills of prescriptions.** The pharmacist may refill prescriptions only when the physician authorizes him to do so, either in writing or orally. The pharmacist must keep a written record of such oral authorizations.

3. **Pharmacist's responsibility.** The pharmacist is responsible for determining that the person who telephones a prescription is actually a licensed physician. The patient is not permitted to transmit an oral prescription or an oral refill authorization.

4. **Prescriptions for narcotics.** The Durham-Humphrey Act does not change the procedures for the writing and filling of narcotic prescriptions; therefore, prescriptions for narcotics cannot be telephoned; they must be in writing.

5. **Over-the-counter sale of drugs.** The Durham-Humphrey Act restricts the over-the-counter dispensing of potentially harmful drugs to a greater degree than ever before. In the future, the labels of all potentially unsafe drugs—which means most of the drugs widely used in modern therapy—will state clearly; "Federal Law prohibits dispensing without prescription." Physicians will be interested to know that the act also enables Federal authorities to prosecute distributors who ignore the need for a prescription.

6. **Labeling of prescription drugs.** Under the Durham-Humphrey Act, the labeling of prescription drugs should carry directions for use, such as the average dosage, the route of administration, and the principal indications. Thus, in addition to products sold over the counter, such as aspirin, antacids, and certain cough syrups, prescription products will also provide detailed information concerning their use on the label.

What does the Durham-Humphrey Act mean to the medical profession? Some of its provisions, such as the restrictions on over-the-counter sales and the refilling of prescriptions, seem to be a step in the right direction. The convenience of telephone prescriptions may also be welcomed as a help to the busy physician.

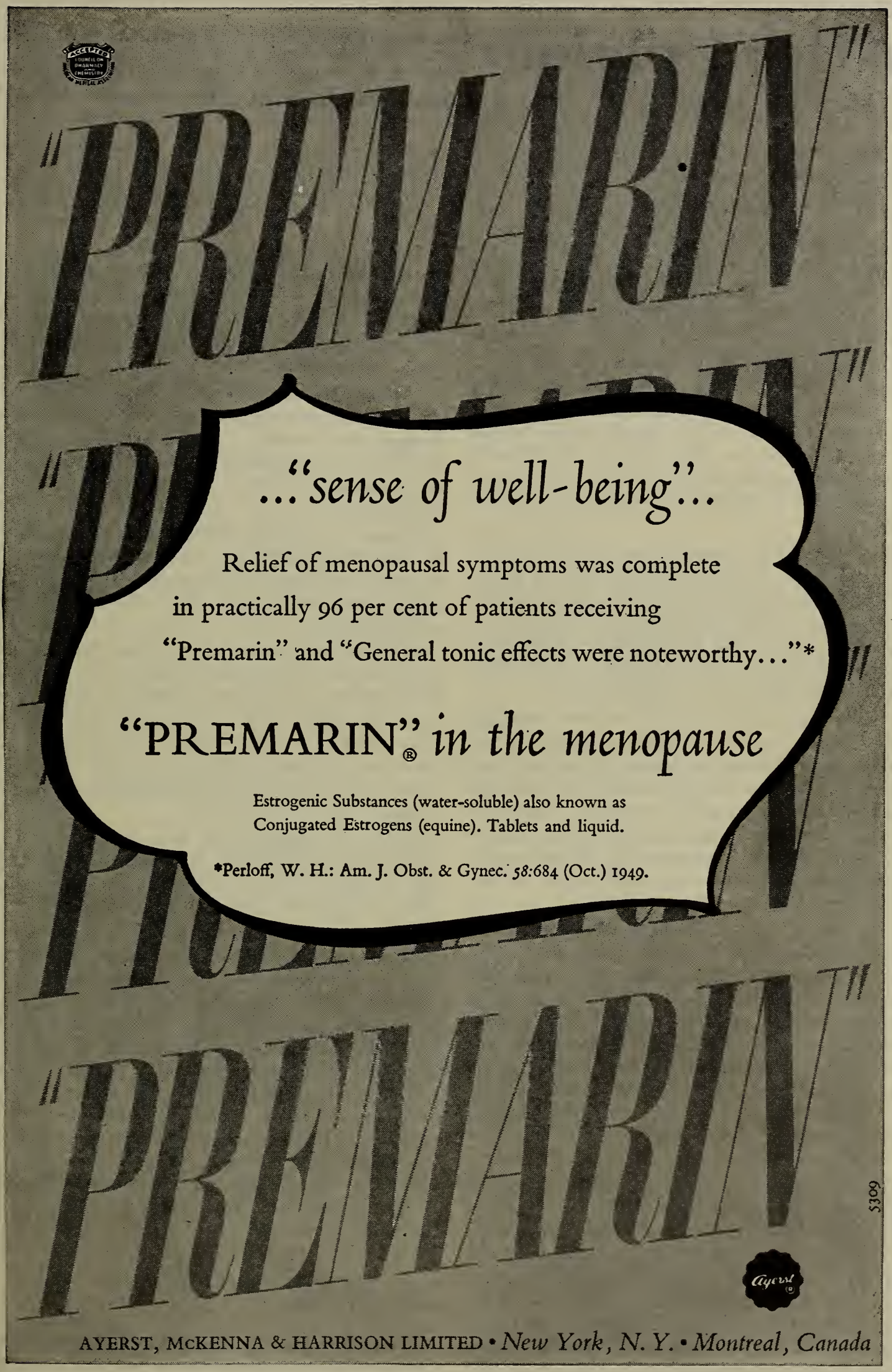
It is probably too early to determine the long-range significance of more informative labeling on prescription drugs, but, regardless of what this change may imply, the American pharmaceutical profession—retailers and manufacturers alike—will, of course, comply with both the letter and the spirit of the law. The physician and pharmacist will therefore find more informative labeling on prescription drugs in the future.

The pharmacist will find this additional information most helpful. Yet this does not detract from one of the main features of the Durham-Humphrey Act, namely the stricter control of prescriptions and refills. In this respect, the Durham-Humphrey Act should have a beneficial effect in minimizing self-medication and encouraging cooperation on the part of the patient.

Postgraduate Continuation Courses Are Listed

Physicians interested in postgraduate continuation courses will find an excellent listing prepared by the Council on Medical Education and Hospitals of the American Medical Association in the June 13 issue of *The Journal of the A.M.A.*

There are a total of 784 courses listed, the courses varying in length from a few days to several months. The semiannual listing covers the period ending January 15, 1954.


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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

STATE, AT LONG LAST, DOES COMMENDABLE JOB ON HEALTH APPROPRIATIONS

One of the significant actions taken by the 100th Ohio General Assembly, now adjourned sine die, was to provide a substantial boost in state appropriation for the Ohio Department of Health.

Although the action is important in terms of dollars and cents, of particular interest is the fact that for the first time in a good many years the State of Ohio will be paying more toward the support of its own state department of health during the biennium starting July 1, 1953, than the department expects to receive in Federal handouts.

Thus, the 100th General Assembly recognized and established the basic principle that it is the responsibility of Ohio to carry the major financial requirements of this department which has for so long been forced into the unhappy position of having to depend on Uncle Sam for well over half of the funds needed for its operations.

Despite warnings expressed in past years by representatives of the Ohio State Medical Association, State Director of Health Porterfield, and others, the General Assembly and the executive department have steadily refused to meet this issue. They have taken the attitude that as long as the Federal Government is willing to pass out grants-in-aid in amounts sufficient to run the department, let Uncle Sam do the job.

This year the issue had to be met. The Federal Government is sharply curtailing handouts to the states. This meant that the state department of health would have to withhold additional money from the local health departments in order to meet its own budget unless the State of Ohio decided that it should do a better job than in the past. Faced with that situation, the 100th General Assembly took very logical and wise action. It increased the appropriations to the department.

Moreover, there was an encouraging indication that more and more members of the General Assembly are beginning to realize that dependency on the Federal Government for financial aid for activities which are state responsibilities and should be underwritten by the state, is bad business. The 100th General Assembly is to be congratulated for its good work. Here's hoping future General Assemblies will continue in this direction and eventually make it possible for the Ohio Department of Health to carry on all of its work without Federal support.

The story as revealed by the figures is as follows:

During the fiscal years, 1952 and 1953, the Ohio Department of Health received from the State of Ohio, exclusive of the state subsidy to local health districts, $1,751,828 for central office operations in carrying out provisions of the Ohio public health laws.

During the fiscal years, 1952 and 1953, the department received a total of $3,147,536 in Federal grants-in-aid of which it had to withhold $1,773,500 for central office expenditures instead of sending the entire amount to local public health units.

Under the General Appropriations Act passed by the 100th General Assembly, the Ohio Department of Health will receive in state funds during the fiscal years, 1954 and 1955, a total of $2,637,558.

During the fiscal years, 1954 and 1955, the department estimates that it will receive a total of $1,898,611 in Federal subsidies—a decrease of about $1,248,925. Thus, the department will receive $885,730 more in state funds during the fiscal years 1954 and 1955 than in 1952 and 1953, which will go far in making up the cut in Federal money.

Also, it is important to note that the total of state appropriations for the year 1954 and 1955 will exceed the total grants-in-aid anticipated from the Federal Government by $738,947.

Many groups went to bat to persuade the General Assembly to take the action referred to, such as representatives of the Ohio State Medical Association, Ohio Tuberculosis and Health Association and Ohio Public Health Association. With the cooperation of leaders in the General Assembly, this paid dividends. It shows what can be accomplished by concerted action. Moreover, the outcome should be considered as a tribute to Dr. Porterfield and his department. The department is doing a good job for the people of Ohio. This was recognized by most of the members of the General Assembly when the chips were down.

P. G. EXPENSES SHOULD BE DEDUCTIBLE

Spokesmen for the A.M.A. are strongly urging Congress, when it ties into the job of revamping the income tax laws, to write in a provision al-

lowing deductions of postgraduate educational expenses incurred by professional men.

This question is now under consideration by the Federal courts in a case involving an attorney. However, it would be well to have the issue settled by legislation, regardless of the outcome of the litigation.

You might drop a line to your Congressman, asking him to look into this and give it his support.

KIEFER'S RECORD WITH F.C.D.A. OUTSTANDING

Dr. Norvin C. Kiefer, former Ohio physician, who has been chief of health services for the Federal Civil Defense Administration, is leaving that post to become chief medical director for the Equitable Life Assurance Society of New York. His many friends in Ohio and throughout the nation will wish him well in his new position. Dr. Kiefer's record of accomplishment in F.C.D.A., in the face of budget difficulties and public apathy, was outstanding. None worked harder to put real life into a vital agency but one which has not as yet received the public support which it deserves because too many figure "it can't happen here." Those in the field who are concerned with civil defense planning and organizing appreciate the valuable service which Dr. Kiefer rendered during his tenure with F.C.D.A.

THANKS, DR. CONARD, FOR A JOB, PAR EXCELLENCE!

Retirement of Dr. Robert Conard as chairman of the Ohio Advisory Committee to Selective Service and as head of the Ohio State Medical Association Military Advisory Committee brings to a close an assignment over and above the call to duty which has few parallels in the history of the Association.

During World War II, Dr. Conard served with distinction as chairman of the Ohio Procurement and Assignment Committee while carrying on his private practice in Wilmington. His record among P and A chairmen of the country was outstanding.

In the Fall of 1950 when the Korean mess began, he was requested by the State Association and the National Advisory Committee to Selective Service to take on a similar assignment. As he had retired from practice, Dr. Conard took on this new job on a full-time basis. Again he served with distinction.

Because of the splendid manner in which he has organized the work of the Ohio Advisory Committee and because of the fair and just way in which he has administered the activities of this important post, Dr. Conard has won the respect of all with whom he has dealt. His successor, Dr. Drew L. Davies, Columbus, will find that he has inherited many assets because of Dr. Conard's excellent work. It should make Dr. Davies' task in handling a disagreeable assignment, even under ideal circumstances, somewhat easier, in our opinion.

The medical profession of Ohio owes a substantial debt of gratitude to Dr. Conard. At the same time, it will, in our opinion, give to Dr. Davies the support and cooperation which he will need, and deserves, in taking over the two posts vacated by Dr. Conard. Here's hoping Dr. Conard will fully enjoy the "life of Riley" which he is planning after these strenuous years of service during two national emergencies.

BEWARE: BLACK MARKET IN GAMMA GLOBULIN

There are some indications that the black market in gamma globulin which has been operating near Pittsburgh has filtered across the border into Ohio.

The nation's supply of gamma globulin is supposed to have been allocated to health departments throughout the country to be used during the current polio season and for other indicated conditions. None is for sale commercially. The short supply available is being carefully distributed to doctors under a specific formula, without cost.

Obviously, physicians who might be approached by the black market operators should promptly reject any offers made. First, because there can be no assurance that the black market serum meets purity tests; secondly, because the racket could destroy the program which has been set up to distribute the serum in a manner which will do the most good for the greatest number of individuals needing it.

OHIO CAN DO A BETTER JOB FOR THE A. M. E. F.

According to the report of the American Medical Education Foundation for the calendar year 1952, a total of $13,177.00 was contributed by 268 Ohio physicians.

During the same period, 1,657 Ohio physicians (which may include some of the 268) made contributions direct to some medical school.

This is not a good showing, considering the fact that there probably are approximately 9,000 physicians in active practice in Ohio.

Your medical school, and other medical schools, need additional financial help. Who's going to do the job: Voluntary private enterprise or the Federal Government? It seems quite clear who should do the job. Here is a way to make a

(Continued on Page 742)


new!
ILOTYCIN
(ERYTHROMYCIN, LILLY)
ETHYL CARBONATE
PEDIATRIC
taste-tested
well tolerated
clinically
effective

tops for tots

For infections in children caused by staphylococci, streptococci, or both . . : the palatability, low allergenicity, and relative freedom from gastro-intestinal upsets make 'Ilotycin,' Pediatric, a prescription favorite. Youngsters (with an occasional incorrigible exception) take it without a struggle. "Tablet-shy" oldsters like it, too.

Lilly

THE ORIGINATOR
OF ERYTHROMYCIN

Formula:

Each 5 cc. (approximately one teaspoonful) contain 100 mg. 'Ilotycin' as the ethyl carbonate.

Dosage:

15 pounds—1/2 teaspoonful every six hours

30 pounds—1 teaspoonful every six hours

60 pounds—2 teaspoonfuls every six hours

How Supplied:

Each package consists of one bottle containing 1.2 Gm. 'Ilotycin' as the ethyl carbonate in a dry, pleasantly flavored mixture; 45 cc. of water are added at the time of dispensing to provide 60 cc. of an oral suspension. After mixing, the suspension is stable for two weeks at room temperature.

tax-free investment that really pays worth-while dividends.

Before too long, the American Medical Education Foundation Chairman of your County Medical Society will be getting in touch with you regarding a pledge for 1953. When he does, sign up. Better yet, why not sign up for an annual pledge so the AMEF can bill you regularly each year?

Let's get Ohio in the top bracket among AMEF donors!

WISE ACTION TAKEN ON FIREWORKS BILL

The House Public Affairs Committee of the present Ohio General Assembly took very wise and sensible action when it killed a bill which would have relaxed the present law regulating the sale of fireworks. It took Ohio a long time before it clamped the lid on the sale of fireworks which had taken a tragic toll of life and injury for so many years. Anything which would weaken the present good laws on this subject would certainly be a long step backward and expose the public—children, especially—to unnecessary hazards.

FINAL DECISION ON THIS QUESTION OF VITAL IMPORTANCE

Congressional committees are tying into one of the biggest and far-reaching medical care programs which confronts the nation, namely: How to handle the medical and hospital needs of the dependents of men in the armed forces?

According to a special commission which just completed a short study of this problem, there are approximately 2,700,000 military dependents. Shall medical and hospital services for them be supplied by officers in uniform and by military hospitals or by civilian physicians and civilian hospitals? How shall the program be financed? What types of illness and disability be cared for? These are but a few of the tough problems involved.

In our opinion, the special commission made the proper recommendation when it declared: "Congress should make an explicit declaration of policy with respect to dependent medical care in order that existing uncertainties and inconsistencies may be removed. The legislation should state what types of illnesses will be treated, whose dependents are eligible, and what types of dependents are entitled to medical care. It should stipulate that where medical facilities are not available, eligible dependents may utilize civilian doctors and medical facilities. The regulations required to ensure proper identification and to prevent abuses of the privilege should also be defined. The Military Services should be authorized to make budget provision for the estimated costs involved."

Developments on this big question should be watched intently by the medical profession. Representatives of the A. M. A. will submit testimony. It may be necessary to secure expressions of sentiment from the grass roots. The Ohio State Medical Association will endeavor to keep County Society officials informed about the hearings which will start shortly. This may well become one of the most vital questions to confront the medical profession for a good long time.

THANKS, MAC; YOU'RE TOPS IN OUR BOOK

The Executive Secretary got a letter the other day from a friend of long-standing, none other than the Hon. J. Harry McGregor, West LaFayette, Ohio, Congressman of the 17th Ohio District. The letter was in reply to a note, congratulating Mac for having used good judgment in the way he voted on a bill which was of importance to the medical profession. Among other things, Congressman McGregor said:

"I still think the doctors are a derned good bunch of people and they do a lot of things they don't get credit for.

"I, for one, am going to do everything I can to see that the steam roller of Socialism does not take them out."

Doctors of the 17th District, please note.

Congressmen like that don't come at a dime a dozen.

SOME PROJECTS YOUR SOCIETY CAN UNDERTAKE, ALSO

Some excellent public relations, as well as inter and intra-professional relations, projects have been going on in Dayton, Cleveland, Columbus and Cincinnati under the sponsorship of the local medical societies.

A series of very successful public health forums were staged in Dayton under the joint auspices of the Montgomery County Medical Society and the *Dayton Daily News*.

In Cleveland and Columbus, "clinics" for physicians' office secretaries and aides were offered by the Cleveland and Columbus academies. They were well attended and practical programs on office public relations and office procedures were presented.

A conference for physicians, lawyers and hospital administrators, with a fine panel discussion, was presented in Cincinnati with the Cincinnati Academy of Medicine representing the medical profession in the planning.

It is suggested that other local medical societies seriously consider projects of this kind. They can get the low-down on how to do it by getting in touch with the officials of all or any of the three societies.

Important Announcement

THE PROGRAM FOR WHICH YOU HAVE BEEN WAITING

The Third Annual Scientific Assembly

of

THE OHIO ACADEMY OF GENERAL PRACTICE

will be held

Wednesday, Thursday

September 16-17, 1953

at

Hotel Cleveland, Cleveland, Ohio

An excellent scientific program is prepared beginning at 1:00 P.M. (Daylight Savings Time) on September 16th and terminating at 12:30 P.M., on September 17th.

The Banquet will be held at the Grand Ballroom, Hotel Cleveland, Wednesday, September 16th, 1953, at 7:00 P.M.

All Doctors and their wives (husbands), Residents, Interns, Medical Students and Nurses are invited to attend.

Every doctor in Ohio will be mailed folders which contain all the data on the program, registration, hotel reservations, pre-registration and banquet ticket reservations for your information and convenience.

Further information or requests may be obtained by writing to

OHIO ACADEMY OF GENERAL PRACTICE

EARL D. MCCALLISTER, M.D., *Secretary-Treasurer*

1113 Bryden Road, Columbus 5, Ohio

In Memoriam . . .

Glenn Adams, M. D., Cincinnati; Pulte Medical College, Cincinnati, 1904; aged 70; died June 21; member of the Ohio State Medical Association. A practicing physician in Cincinnati for 49 years, Dr. Adams for a number of years operated three industrial hospitals there. He was active in the local Republican Club and at one time served on the city council. A fancier of dogs and horses, he conducted a radio program and edited a national magazine on the subject. He was a member of several Masonic bodies. Surviving are his widow, also a son and four daughters by a former marriage.

James T. Clear, M. D., Cincinnati; University of Cincinnati College of Medicine, 1912; aged 63; died June 7; member of the Ohio State Medical Association; the American Medical Association, and Fellow of the American College of Surgeons and the International College of Surgeons. A practicing physician in Cincinnati since completion of his medical training, Dr. Clear was active on the staffs of a number of hospitals, and was one of the founders of the Cincinnati Surgical Society. Affiliations included the Western Hills Country Club, the Cincinnati Club, the Catholic Church and the Knights of Columbus. Surviving are his widow; a son, Dr. James J. Clear, also of Cincinnati; four daughters, and his mother; also two brothers.

Charles R. Coate, M. D., Whittier, Calif.; Medical College of Ohio, Cincinnati, 1907; aged 75; died May 26; former member of the Ohio State Medical Association and later a member of the California State Medical Association. Dr. Coate practiced in Pleasant Hill before moving to California in 1924. He is survived by his widow, two sons and a daughter.

Gerald Foster Denyes, M. D., Delray Beach, Fla.; Queens University Faculty of Medicine, Canada, 1916; aged 57; died June 22; member of the Ohio State Medical Association; member of the American Medical Association through 1952. A practicing physician for a number of years in Toledo, Dr. Denyes moved to Florida last winter. He was a veteran of World War I, having served with a Canadian medical unit.

Francis Asbury Duckwall, M. D., Dayton; Medical College of Cincinnati, 1877; aged 101; died June 24; former member of the Ohio State Medical Association. A life resident of the Miami Valley area, Dr. Duckwall was born in a log cabin on the edge of Germantown. When he was 14 his family moved to Brookville. After teaching for two years, he entered the Ohio Medical College and received his degree in 1877. He entered practice at West Baltimore, three years later moved his office to Enon and in 1891 went to Dayton. He retired in 1931 after more than a half century of practice, but returned to practice during World War II because of the shortage of doctors. Dr. Duckwall was a charter member of the Nomad Club, a member of the Methodist Church, the Kiwanis Club and the Four Score Sunshine Club. Survivors include a daughter and two grandsons, one of whom is Dr. Henry M. Duckwall, also of Dayton.

Milton E. Hayes, M. D., Youngstown; University of Pittsburgh School of Medicine, 1895; aged 85; died June 26; former member of the Ohio State Medical Association, last in 1946. Dr. Hayes practiced in Pittsburgh for five years after graduating from medical school, and moved to Youngstown about the turn of the century. He was a recipient of the 50-Year Pin and Certificate of the Ohio State Medical Association. From 1920 to 1935 Dr. Hayes served as Mahoning County Coroner. He also served as city physician and as chief of the city's venereal disease clinic. A 50-year Mason, he was active in numerous Masonic bodies; was a past-president of the Lions Club, former vice-president and director of the Tippecanoe Country Club, and a member of the Elks Lodge. Two sisters survive.

Walter M. Joseph, M. D., Cleveland; Friedrich Wilhelms University, Berlin, 1921; aged 56; died June 26. Dr. Joseph had been a practicing physician in Cleveland since 1936. His widow and two sons survive.

Ada L. Malick, M. D., Piqua; University of Illinois College of Medicine, 1900; aged 78; died June 30; former member of the Ohio State Medical Association, last in 1930. Dr. Malick moved to Piqua in 1903 and practiced there for a number of years before her retirement.

J. Grant Marthens, M. D., Dayton; Syracuse University College of Medicine, 1907; aged 69; died on or about June 18; member of the Ohio State Medical Association through 1949. Dr. Marthens moved to Dayton in 1909 and practiced there until his retirement in 1948 when he moved to Florida. He returned to Dayton last September. Dr. Marthens was known for his pioneering work in the field of venereal disease. During World War I, he served with the Army and was in charge of V. D. care. Following his discharge, he formed a clinic to study treatment of those committed to Dayton State Hospital for insanity due to V. D. and later was named to direct Dayton's first clinic for treatment of syphilis. He was instrumental in having written into Ohio law the pre-marital blood testing and the pre-natal blood testing laws. Dr. Marthens was a past exalted ruler of the Elks. His widow survives.

1 *to escape pollens*



2 alternatives for the hay fever patient

2 *to relieve symptoms*



Pyribenzamine®

hydrochloride
(tripelennamine hydrochloride Ciba)

Once atop Pike's Peak, your hay fever patient can enjoy freedom from pollens. But for patients who must remain in a high-pollen environment, you can institute this effective therapy: one or two Pyribenzamine tablets, 3 or 4 times daily.

Alone and as an adjunct to desensitization, Pyribenzamine has proved effective in relieving hay fever symptoms, as evidenced by thousands of published case reports. On the basis of this evidence, no other antihistamine combines greater clinical benefit with greater freedom from side effects.

For your prescription needs, Pyribenzamine 50 mg. tablets are available in bottles of 100 and 1000 at all pharmacies.

Ciba *Ciba Pharmaceutical Products, Inc., Summit, N. J.*

2/1920M

Sherman G. Martt, M. D., Pomeroy; University of Louisville School of Medicine, 1894; aged 83; died June 18; former member of the Ohio State Medical Association, last in 1949. His long service in the medical profession was recognized when Dr. Martt was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He had practiced for a number of years in Pomeroy and previous to that was in Chester. Survivors include his widow, a son, a daughter and a step-daughter.

Benedict Olch, M. D., Dayton; Harvard University Medical School, 1919; aged 59; died June 27; former member of the Ohio State Medical Association; diplomate of the American Board of Internal Medicine; Fellow of the American College of Physicians. Dr. Olch practiced in Dayton from 1920 until about 12 years ago when he retired because of ill health. He was a member of the Discussion Club, B'nai B'rith and the Temple. Surviving are his widow, his mother, a sister and three brothers.

Andrew S. Robinson, M. D., Akron; Western Reserve University School of Medicine, 1914; aged 63; died on or about June 16; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Internal Medicine; Fellow of the American College of Physicians; member of the American Association of Industrial Physicians and Surgeons. Dr. Robinson engaged in private practice in Akron until he joined the Goodyear Tire & Rubber Co. in 1943. He was a veteran of World War I, having served with the British Army Medical Corps. Survivors include his widow, a son, a daughter and two sisters.

Albert H. Schilling, M. D., Mariemont; University of Cincinnati College of Medicine, 1942; aged 38; died June 23; member of the Ohio State Medical Association; member of the American Medical Association; member of the Southeastern Ohio Society of General Practitioners. Dr. Schilling served as a Captain with the Medical Corps during World War II and since the war had been practicing in the Mariemont area. He was a member of the Masonic Lodge and Nu Sigma Nu. Surviving are his widow, two sons, a brother, a sister and his parents.

Dr. Jonathan Forman, Editor of *The Journal,* was a guest participant in a panel discussion on fluoridation of the public water supplies before a recent meeting of the Columbus Dental Society. Drs. Paul K. Kitchin and Hamilton B. G. Robinson, of the O. S. U. College of Dentistry, spoke in favor of this medication if and when the public asks for it. Dr. Forman insisted that the experimental data on the use of fluorine in drinking water is not adequate and that there is no data as to its eventual effect on the adult population.

Radiation Protection Course To Be Given in Cincinnati

The Radiological Health Training Section, Environmental Health Center, Public Health Service will present a course in radiation protection for industrial physicians during the period September 15-October 30.

This course is intended primarily to present the fundamentals of radiation and radiation protection to the graduate students at the Institute of Industrial Health of the University of Cincinnati but other physicians are welcome. The presentation will be divided into two phases. On September 15, 16, and 17, three full days of instruction will be given. Following this, one afternoon a week for six weeks will complete the course. No tuition is required.

For further information or application write: Simon Kinsman, Chief, Radiological Health Training Section, Environmental Health Center, Cincinnati, Ohio.

New Psychiatric Hospital To Be Built in Cleveland

Plans have been completed for construction of the Howard M. Hanna Memorial Hospital in the University Hospitals group of Cleveland—the cost to be $2,250,000.

The new psychiatric center will have accommodations for 93 patients, extensive facilities for outpatients, research facilities, etc.

More than a million dollars of the cost of the new building comes from a gift of the Hanna family and its friends.

Staffing of the new unit will be under direction of Dr. Douglas D. Bond, director of the Department of Psychiatry, Western Reserve University School of Medicine.

Americans Seem To Be Safer On the Job Than Off

For every day's work lost in American industry through job accidents or illness, nine are lost through some off-the-job ailment, the Public Health Service Division of Occupational Health, reported.

Approximately 2,000,000 men and women, it reports, are absent from work every day because of sickness or injury. Of the total:

Ten per cent are due to job accident or ailment;

Thirty per cent are due to emotional disorders, some of which may be related to the work situation;

Sixty per cent are due to such illnesses as the common cold, influenza, digestive disorders, heart disease and non-industrial injuries.

The report concedes that some of the reported illnesses may be by persons who are actually taking time off for personal reasons.

Licensed by Endorsement . . .

A Number of Physicians Are Accredited by State Medical Board To Practice in Ohio Through Reciprocity Agreement with Other States

THE State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states (intended residence and medical school of graduation also is given:

April 7—Robert F. Beckley, Cleveland, Temple University; Christian J. deWinter, Akron, Cornell University; Robert W. Finch, Dayton, St. Louis University.

June 16—Woodruff C. Adams, Canton, Meharry Medical College; John P. Ambuel, Columbus, University of Chicago; Marvin M. Anderson, Springfield, Meharry; Jeanne E. Andrews, Cleveland, University of Wisconsin; Jacob S. Araj, Newark, American Univ. of Beirut; Siegmund Auchhiesiger, Columbus, University of Turin (Italy);

Joseph G. Barkey, Findlay, Indiana University; Richard F. Barronian, Parma, Tufts College; Robert B. Beam, Springfield, Indiana University; Robert F. Binkley, Toledo, St. Louis University; Harry A. Black, Jr., Orrville, University of Pittsburgh; Robert Bogan, Akron, New York University; Alvin L. Bridges, Dayton, Meharry; Frederick Brockmeier, Cincinnati, University of Tennessee; Robert V. Bruchs, Youngstown, Marquette; Clayton E. Buhl, Cleveland, University of Nebraska; Ralph B. Burner, Gallipolis, Medical College of Virginia;

Badih Chagerben, Cleveland, University of Guayaquil, Ecuador; William E. Copeland, Columbus, Medical College of Virginia; Patrick H. Curran, Findlay, Long Island College; John R. Damron, Jackson, University of Louisville; Duane C. Deen, Columbus, University of Pittsburgh; Gerard H. DeGenova, Shadyside, St. Louis University; Cornelius F. Derrick, Toledo, St. Louis University; Stanley L. Dobrowski, Elyria, St. Louis University; Walter I. Droba, Cleveland, St. Louis University; Thomas M. Dugan, Parma, University of Pittsburgh; Ensor R. Dunsford, Jr., Columbus, Vanderbilt;

Edward J. Ettl, Cleveland, Indiana University; James L. Farkas, Toledo, St. Louis University; Donald C. Fischer, Cincinnati, St. Louis University; David T. Fitzelle, Alliance, University of Rochester; Forrest W. Freeman, Dayton, Indiana University;

Clarence L. Gantt, Columbus, Bowman-Gray School of Medicine; Margaret E. Gantt, Columbus, Bowman-Gray School of Medicine; Samuel Garson, ----------, University of Stefan Batory (Poland); Frank G. Gatti, Portsmouth, University of Louisville; Paul G. Geiss, Cincinnati, Syracuse; Karl K. Grubaugh, Mansfield, University of Vermont;

Henry M. Hanson, Jr., ----------, Northwestern; Melvin W. Harris, Canton, Long Island College; Richard H. Hart, Akron, University of Illinois; Harry R. Hittner, Middletown, Indiana University; John S. Horan, Cleveland, University of Tennessee; Konstantins Jakobsons, ----------, University of Latvia; Robert L. Jenkins, Jr., Youngstown, George Washington University;

John D. Karns, Dayton, Indiana University; Frederick D. Keller, Belpre, University of Maryland; Clement E. Kelley, Jr., Lima, Indiana University; Frank W. Kellogg, Cincinnati, University of Michigan; Lionel R. King, Cincinnati, University of Louisville; Edward H. Koster, Fremont, Temple University;

Charles F. Lehmenkuler, Springfield, St. Louis University; Samuel W. Lykins, Cleveland, University of Louisville; Richard E. Lyons, Cleveland, University of Buffalo;

James D. McCaffrey, Dayton, Washington University; Edward R. Malia, Cleveland, Jefferson; Edward W. Mencher, Lodi, Georgetown University; Marvin C. Menne, Dayton, St. Louis University; William J. Meyer, Toledo, St. Louis University; Charles Miller, Jr., Dayton, Washington University; Milo Kirk Miller, Jr., Canton, University of Rochester; Carl H. Moberg, Cleveland, University of Illinois; William R. Moore, Cleveland, Indiana University; Robert W. Moses, ----------, Indiana University; Leo Muido, ----------, University of Tartu (Estonia);

Donald R. Nelimark, Youngstown, University of Minnesota; Donald S. Nelson, Akron, George Washington University; Edwin C. Neville, Youngstown, St. Louis University; Carl W. Noble, Dayton, University of Louisville; John J. Nolan, Parma, University of Pennsylvania; Frank E. Nulsen, Cleveland, Harvard;

Leon S. Obuszkewycz, ----------, Catholic University of Louvain (Belgium); David S. Palmstrom, Ravenna, Medical College of Virginia; Stanley M. Pariser, Cleveland, Hahnemann; Herman W. Reas, Defiance, St. Louis University; Audrey G. Regan, Cleveland, New York Medical College; Richard H. Retter, Columbus, University of Wisconsin; Emmanuel R. Riff, Cleveland, Duke University;

F. Kraft Ritter, Port Clinton, St. Louis University; James M. Robertson, ----------, Temple University; James A. Rodeghero, Germantown, St. Louis University; Donald B. Rogers, German-

(Continued on page 750)

When you suspect antibiotic hypersensitivity

ALWAYS CONSIDER



ERYTHROCIN*

...A SELECTIVE ANTIBIOTIC



ORALLY EFFECTIVE

against staphylococci, streptococci and pneumococci —especially indicated when patients are allergic to penicillin and other antibiotics or when the organism is resistant.



A DRUG OF CHOICE

against staphylococci—because of the high incidence of staphylococcal resistance to other antibiotics.



A DRUG OF CHOICE

because it does not materially alter normal intestinal flora; gastrointestinal disturbances rare; no serious side effects reported.



ADVANTAGEOUS

because the special acid-resistant coating developed by Abbott—and Abbott's built-in disintegrator—assure rapid dispersal and absorption in the upper intestinal tract.



Use ERYTHROCIN

in pharyngitis, tonsillitis, scarlet fever, pneumonia, erysipelas, osteomyelitis, pyoderma and other indicated conditions. Abbott

*Trade Mark
Erythromycin, Abbott, *Crystalline*

town, St. Louis University; Ralph W. Royer, Mt. Vernon, College of Medical Evangelists; William K. Runyeon, Cleveland, University of Pennsylvania; James H. Ryan, Toledo, St. Louis University;

Benjamin H. Saunders, Jr., Findlay, Harvard; Jack Schechter, Toledo, Temple University; Albert F. Schoeck, Cleveland, St. Louis University; Victor T. Scoville, ----------, Wayne University; John W. Sellett, Fremont, University of Illinois; Richard M. Shaw, Cleveland, University of Lwow (Poland); Robert G. Sheperd, Toledo, St. Louis University; Norman P. Shumway, Cleveland, University of Pennsylvania;

Alfred F. Slivinski, Columbus, Johns Hopkins; Edward J. Smanik, Toledo, St. Louis University; Robert N. Smith, Toledo, University of Nebraska; Eugene M. Socha, Lorain, Marquette; Charles C. Sorenson, Cleveland, University of Utah; Minnie S. Steinhauer, Yellow Springs, University of Toronto; Selig S. Strassman, Cleveland, Hahnemann;

Robert A. Tennant, Middletown, Kansas University; Carr A. Treherne, Dayton, Meharry; Clinton W. Trott, Mt. Vernon, College of Medical Evangelists; Anthony D. Vamvas, Jr., Akron, Boston University;

James L. Webster, Dayton, College of Medical Evangelists; Sylvan L. Weinberg, Dayton, Northwestern; Fay B. Weinstein, Cleveland, Temple University; Thomas J. Williams, Columbus, Northwestern; Wladimir Wreciona, Nelsonville, University of Lwow (Poland); Daniel C. Wunderman, Warren, University of Texas.

Toronto (Ohio)—A wading pool for children was dedicated in June to the memory of the late Dr. Horace D. McCulloch who practiced in the town for forty years before his death in January. The project was sponsored by fellow members of the Toronto Kiwanis Club, with contributions also from various local church, social, fraternal and industrial organizations.

Ohioans Are Named To Key Posts In A. M. A. Sections

A number of Ohio physicians were honored by being elected officers or delegates of specialty sections of the American Medical Association during the New York Annual Session, June 1-5.

Dr. Joseph Placak, Sr., Cleveland, was elected alternate delegate of the Section on Diseases of the Chest.

Dr. Irvine H. Page, Cleveland, was elected chairman of the Section on Experimental Medicine and Therapeutics.

Dr. Paul A. Davis, Akron, continued as delegate of the Section on General Practice.

Dr. A. Carlton Ernstene, Cleveland, was elected secretary of the Section on Internal Medicine.

Dr. Walter Solomon, Cleveland, was elected chairman, and Dr. Walter J. Zeiter, Cleveland, secretary, of the Section on Physical Medicine and Rehabilitation.

Dr. John J. Phair, Cincinnati, was elected vice-chairman, and Dr. Frank Princi, Cincinnati, secretary of the Section on Preventive and Industrial Medicine and Public Health.

Dr. Robert M. Zollinger, Columbus, was elected vice-chairman of the Section on Surgery, General and Abdominal.

Dr. Charles C. Higgins, Cleveland, was elected vice-chairman of the Section on Urology.

National Dental Meeting

Between three and four hundred dentists, including top dental and medical researchers, are expected to attend the 10th annual meeting of the American Institute of Dental Medicine, at Desert Inn and El Mirado, Palm Springs, California, October 25-29.

Included on the program is a talk by H. B. G. Robinson, D. D. S., Ohio State University College of Dentistry, whose subject is "The Oral Pathologist Considers Focal Infection; Clinical Aspects of Intraoral Ageing and Recalcitrant Diseases of the Oral Mucosa."



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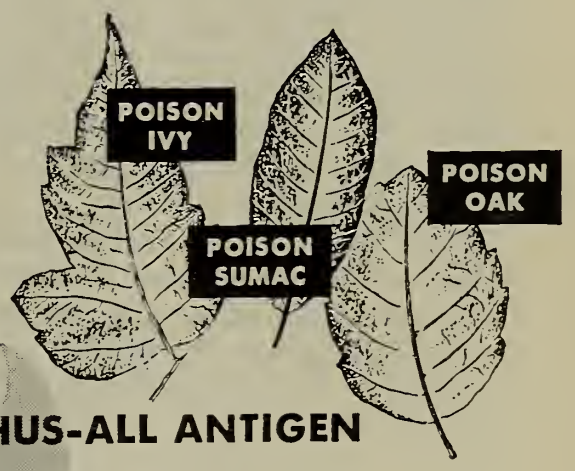


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Backing Into Socialized Medicine . . .

Former Congressman Writes Thought-Provoking Article, Contending That Militarism Is Causing Profound Changes in Medical Practice

IN A RECENT ISSUE of the weekly publication, *Human Events*, Howard Buffett, who retired last year from Congress after serving four terms as representative from the Second Nebraska District, contributed an article entitled, "Backing Into Socialized Medicine."

The observations and conclusions presented by Mr. Buffett are so timely and thought-provoking that *The Journal* believes they should be analyzed by all physicians. For that reason it presents herewith, Mr. Buffett's studious article with the admonition: Read it carefully and then as citizens, act when and how you can to stop the trends which the article refers to. Wrote Mr. Buffett:

Socialized medicine ought to be a dead issue in America. In a number of elections its advocates have taken repeated shellackings, to the point where candidates for office hardly dare mention it. This situation is testimony to the political effectiveness of the doctors who fought socialized medicine, as well as to the fact that Americans will reject any socialistic proposal that is properly labelled; that is why the word "socialism" is assiduously avoided by its avowed proponents, like the New Dealers or the Americans for Democratic Action.

Nevertheless, we are edging towards socialized medicine, whether we want it or not. We are being dragged into it as a result of our attempt, since Pearl Harbor, to meddle in the affairs of the world. We are backing into it by ways of militarism.

VETERANS AND DEPENDENTS

Out of World War II emerged over fifteen million American veterans, each with a lifetime claim on the government for free medical care—subject to some conditions. Then there are about 3,700,000 men and women now in uniform who have a "plus" claim on society for medical attention; the "plus" is the inclusion of their dependents and families in the subsidy. To be exact, the "plus" is not entirely free, for the dependents are required to pay certain modest charges for such medical services as they receive.

Altogether, there are almost 20,000,000 Americans, mostly on the underside of fifty, who enjoy this special attention.

The government has sought to lessen this continuing strain on its budget by attaching some technical restrictions to the use of the privilege. The regulations call for dividing all medical cases into two broad classifications, service-connected and non-service-connected. An ailment that can be positively traced to service duties entitles the veteran to free and unlimited medical attention for the rest of his life. Non-service-connected disabilities are treated free in Veterans' Hospitals only if the patient signs an application in which he declares his inability to pay. His signature is final; it is not checked or questioned in any way. The idea is to protect the ailing veteran from embarrassment.

64 PER CENT NON-SERVICE

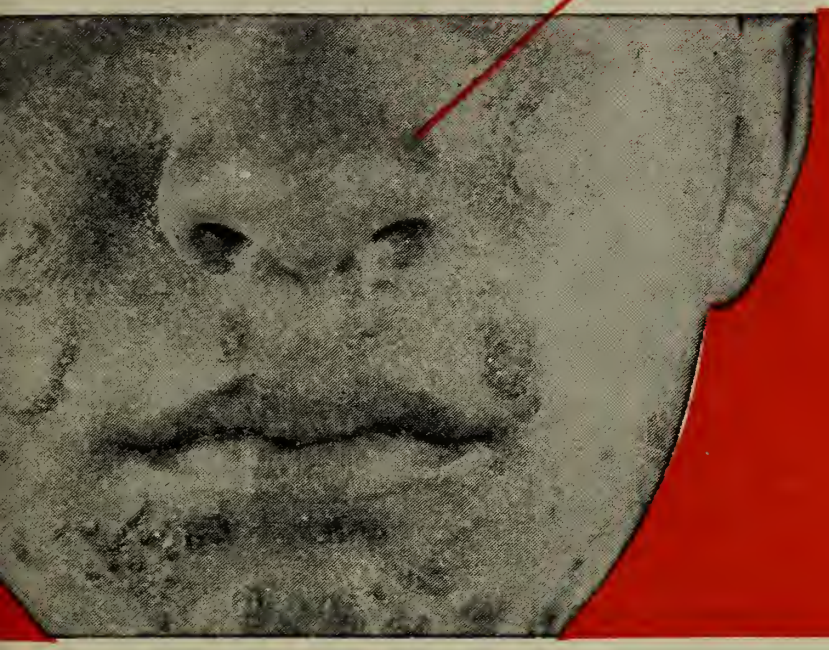
Naturally, most post-service health troubles are post-service developments; we all acquire more miseries as we get older. Also, like most of us, veterans have their financial troubles. It is not strange, therefore, that a recent survey came up with the statistics that 64 per cent of veteran hospital beds were occupied by patients suffering from non-service ailments. That left only a third of the available beds for service-connected cases, which explains why so many deserving veterans were kept on the waiting list. Quite a headache for the Veterans Administration.

The financial and medical difficulties arising from the claims of veterans already on the rolls are as nothing to what looms ahead. Under the Selective Service law, about 900,000 young males are conscripted each year, and conscription automatically entitles them to medical care for the rest of their lives—according to regulations. Should Selective Service, often referred to as sugar-coated Universal Military Training, be converted into full-fledged U.M.T. in a comparatively few years at least half the nation's population — not counting dependents — would have a claim on Uncle Sam, M.D. Since U.M.T. would be a continuing process, the claim on said doctor's services would grow and grow.

STRAINING CIVILIAN NEEDS

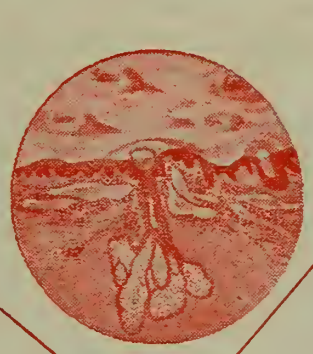
Nor does the problem stop there. As the government siphons off the medical personnel needed for sick veterans or soldiers in service, the talent available for the civilian population diminishes. The V.A. now employs 7,000 doctors regularly and an equal number on call. This creates an artificial shortage of doctors for the rest of the population, a shortage that is not relieved by the medical schools simply because more and more of their graduates are drawn into the services, either voluntarily or via the draft.

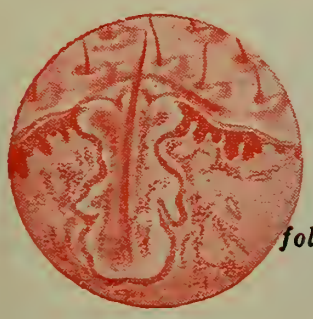

impetigo

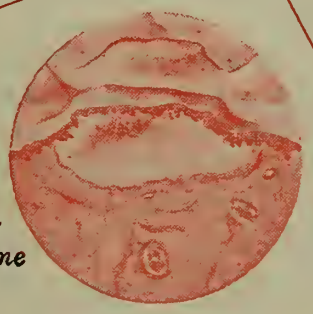


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1. *Bednar, G. A.: South. M. J. 46:298 (March) 1953.*
2. *Wright, C. S. et al.: A. M. A. Arch. Dermat. & Syph. 67:125 (Feb.) 1953.*
3. *Robinson, H. M. et al.: South. M. J. (in press).*
4. *Andrews, G. C. et al.: J. A. M. A. 146:1107 (July 21) 1951.*

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This false scarcity of doctors creates the very conditions which the advocates of socialized medicine decry. Following the law of supply and demand, the fees of the fewer available doctors rise. And as a matter of necessity, their offices are overcrowded and ther examinations are often forced to be hasty and perfunctory. Thus the inflammatory charges of the socialists acquire substance—if one overlooks the cause of the condition, which is the absorption of a large part of our medical profession by the military.

IS THERE A DOCTOR SHORTAGE?

Yet, the facts indicate that the hullabaloo about the shortage of doctors in America is just hullabaloo. In 1940, before the war, there was no shortage. In fact, there was a shortage of patients, for many young and well-trained doctors were finding it difficult to establish practices. What then happened to create the present apparent shortage?

In 1940 there were 175,382 medical doctors in the United States. By 1952 the number had increased to 211,680, a gain of 36,298. To be sure, the population of the country had increased by 15 per cent—but the doctor population had increased by 21 per cent.

Where are all these doctors? As stated above, a good portion of them are in the employ of the Veterans Administration. But, many more are in military uniforms, stationed wherever American troops are stationed. The Army has one doctor for every 275 men and women in the service. The Navy personnel seem to be more fragile; they need a doctor for every 195 men in uniform. The Air Force, somewhat less demanding, gets along with a doctor for every 315. While those in combat areas could understandably be in need of such liberal medical service, most of the military forces are, thank God, not so occupied, and on the whole they constitute the healthiest segment of our entire population.

As for the rest of us, we must get along with one doctor to 710 possible patients. Whether that is adequate we do not know. But, we do know that many of our small communities cannot secure permanent doctors; and we do know that the available civilian doctors are carrying a heavy load. None of us, not even the overworked doctors, would complain about this condition, if it were created by the need of medical attention on the battlefield, or even in the service hospitals. There is a suspicion, however, that the large ratio of doctors to men in uniform is in line with the program of those who would collectivize America.

GOOD INTENTION—BAD PRINCIPLE

A government that conscripts its youth is under obligation to provide them with adequate medical care, regardless of any shortage of doctors for the civilian population; no one can quarrel with that. And it is easy to see that the claim of veterans to medical help under varying circumstances also has justification. But, when we think of the likely impact of this situation on the future of private medical practice, the problem takes on an aspect quite unrelated to the duty of the country to its soldiers.

Not only will the soldier come out from the service with a firm conviction that he is entitled to all he can get from the government, but the doctors who have had a taste of regimented medicine, with its freedom from responsibility to the patient, will most likely favor a continuance of the sinecure in civilian life. Not having had any experience with private practice, he will not understand its superiority and will not therefore be inclined to fight against socialized medicine. The struggle against socialization has been waged by American doctors who had built up practices in the hard, competitive way. Their minds had not been socialized. But, the breed of doctors in the offing will have had a different training.

ORIENTED IN BUREAUCRACY

The doctor who enters the army directly from medical school, or after his internship, knows nothing but bureaucratic medicine, and has no experience by which to measure its disadvantages. Just as the young graduate who goes to Washington immediately after he receives his diploma soon makes a perfect mental adjustment to statism, so the doctor in uniform learns how to get along by pleasing his superiors (not his patients), and how much easier it is to make reports than diagnoses. Besides, the regularity of the pay, though inadequate, is an immediate inducement that offsets the promise of the future in private practice. Why hang up a shingle and wait for patients? The government has lots of them. And why fret about fees and collections? The monthly check from the government is always good.

MILITARISM GREASES THE SKIDS

So then, socialized medicine can slide into the American way of life without any new legislation. This would be all right to those who are hell-bent for socialism. To those of us who have always known that militarism and socialism are related, the situation is dark; unless we can get rid of militarism we cannot prevent the coming of socialism.

Perhaps the solution of this problem lies with the doctors who know of the dangers to medicine, both as a science and an art, in socialization. They have thus far put up a good fight, and maybe they can figure out a maneuver to prevent the destruction of the profession by the flank movement from militarism. Perhaps the young

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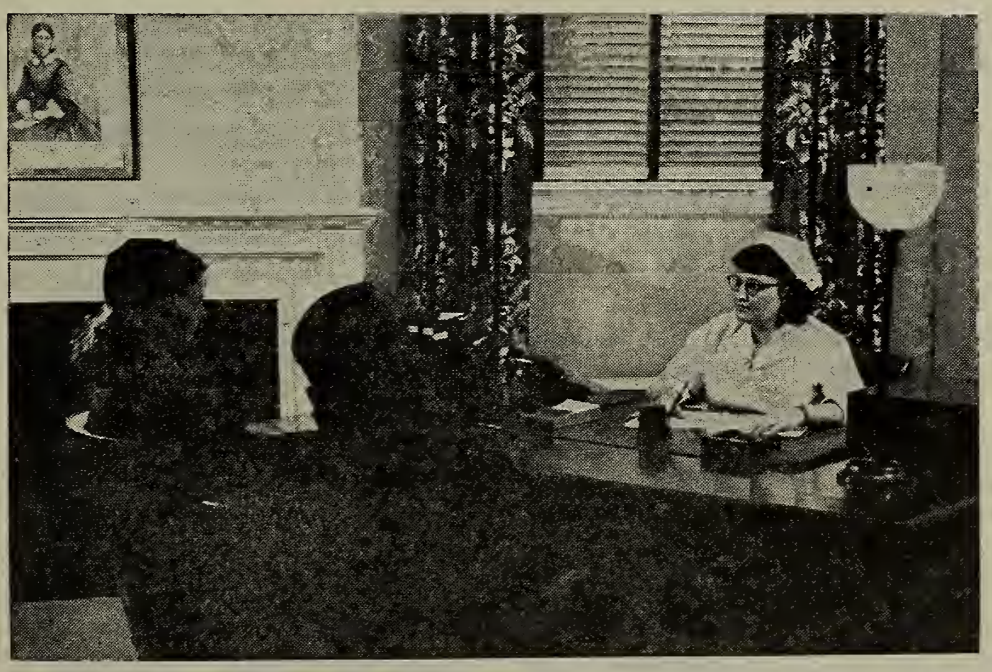
A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the Ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as prostatic resection.

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doctors can be taught that regimented medicine is bad for them and the country.

56-YEAR DELAYED ACTION

To those who refuse to see the danger in the present trend, and who view the situation as a temporary post-war phenomenon, I offer a bit of history. The Civil War ended in 1865. But the largest number of pension recipients was not reached until 1915, 50 years later, when 691,606 Civil War pensions were being paid. The peak of expenditures for Civil War pensions was reached in 1921. From this experience it is fair to conclude that the medical demands arising from our two World Wars will grow with the years, and will continue to provide the advocates of socialized medicine with plausible argument.

The veterans are not to blame for this situation. They bear little or no responsibility for it. When they were drawn into the bloody and futile overseas ventures, they were entirely too young and inexperienced to pass judgment on the policies that disrupted their lives, or to understand what the consequences of these ventures would be.

One can express disappointment, however, that their leadership has not supported the small band of patriots in and out of Congress who have resisted the drainage of our economy to the point where future payments to widows, orphans and wounded will be of questionable value. The continuing wastage of our wealth since World War II, by way of handouts, while working into the hands of our socialist-minded, must in the end weaken the nation's ability to discharge its solemn duty to the veterans.

Cataract Treatment with Fish Lens Protein Exposed by A.M.A.

Claims in regard to a non-surgical treatment of cataracts with fish lens protein, which appeared in a popular magazine, have been exposed in June 20 issue of *The Journal of the A. M. A.* as useless and potentially dangerous.

Principal author of the article in the popular magazine is R. F. Shropshire, who does not have a medical degree. Two co-authors are physicians.

A detailed report prepared by the Committee on Ophthalmology of the Division of Medical Sciences of the National Research Council, concludes as follows:

"Because of the total lack of evidence that the lens antigen treatment of cataract described by Mr. R. F. Shropshire *(Science* 12 September 1952) has any efficacy; because adequate evidence is now available to the Committee that it is, in fact, without demonstrable efficacy; and because treatments of this type have been thoroughly investigated in the past and proved not only invalid but potentially dangerous to the patient; this Committee does not recommend further investigation of this treatment by any agency."

Byers Enters Service; Succeeded By Yantes as Chairman of Rural Health Committee

Dr. Edmond K. Yantes, Wilmington, has been appointed chairman of the Committee on Rural Health of the Ohio State Medical Association to succeed Dr. J. Martin Byers, Greenfield, who has accepted a commission as major in the Army Medical Corps Reserve.

In receiving Dr. Byers' resignation, President Paul A. Davis conveyed the appreciation of the Association for his splendid work as chairman of the committee, stating that "under your guidance, the committee has made real progress and is regarded throughout the country as one of the outstanding groups in this field."

Dr. Byers has been a member of the committee since 1948 and has served as chairman since 1950.

Other positions held by Dr. Byers were: member of the Highland County Board of Health; vice-president of the Ohio State Coroners' Association; director, Highland County Civil Defense Unit; Highland County Coroner; and president of the Greenfield Rotary Club. He is a 1938 graduate of the Ohio State University College of Medicine.

Dr. Yantes has been a member of the Committee on Rural Health since 1948, and has served as a member of the Association's Committee on Medical Service Plans. He is currently serving on the Board of Directors of Ohio Medical Indemnity, Inc., Ohio's Blue Shield Plan.

Recently he was given the Silver Beaver Award for outstanding work in the Boy Scout movement. He is currently chairman of the Anthony Wayne District Committee of the Boy Scouts of America.

He attended premedical school at the Ohio State University and graduated from Jefferson Medical College in 1942.

Both Drs. Byers and Yantes are natives of Columbus. Both were active as lecturers in the first and second annual O. S. M. A. special talks for Senior Students in Medicine, sponsored at the Ohio State University College of Medicine by the Committee on Rural Health.

Swan Hospital in Cambridge Closes After Many Years of Service

The Swan Hospital, Cambridge, discontinued operation on June 30 after 23 years of continuous service under that name, Dr. George F. Swan, managing director and chief of staff, announced on authority of the board of directors.

Recent illness of Dr. George Swan was a deciding factor in the action. He and his brother, Dr. Reo M. Swan, have been associated in the operation of the hospital. Both will continue in practice, they announced. Dr. George Swan is a former member of The Council of the Ohio State Medical Association.



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Activities of County Societies . . .

CUYAHOGA

Dr. John Budd is the new president of the Academy of Medicine of Cleveland, having been elected at a recent meeting of the Board of Directors. He served as vice-president last year, and succeeds Dr. Charles L. Hudson in the high office.

Dr. George L. Sackett was elected vice-president and chairman of the Executive Committee. Dr. George R. Krause was reappointed to the position of secretary-treasurer.

The membership at large elected eight new members to its 24-member Board of Directors, members of which rotate on a three-year basis. The new directors are: Drs. Donald C. Darrah, John J. Grady, Charles L. Hudson, Chester R. Jablonoski, A. Macon Leigh, Edward A. Marshall, Paul J. Schildt and Edward W. Shannon.

FRANKLIN

The Columbus Academy of Medicine has instituted a Doctor-of-the-Day program to take care of emergency calls, it was announced in the July Academy *Bulletin.*

All Academy members, except those excused for age or illness, have been asked to volunteer in the civic service. Specialists and general practitioners alike will take part. Under the program, two physicians are on call for the 24-hour period.

It is emphasized that the officers-of-the-day are for emergency purposes only. Physicians will be expected to answer calls from their own practices and to provide substitutes when not available.

The Academy has had an emergency call service for some 18 years through the Medical Bureau and announces that it is strengthening the service to meet changed conditions.

The *Bulletin* further announced that the Professional Relations Committee is making preliminary plans for a series of Health Forums to be open to the public. Tentative plans call for a series of four evening sessions spaced two weeks apart, next October and November. The forums will be sponsored in cooperation with the *Columbus Dispatch,* local newspaper. Dr. Harrison Evans is chairman of the Professional Relations Committee.

TRUMBULL

Participating in the Ohio Sesquicentennial Year observance, the Trumbull County Medical Society on June 28 made a pilgrimage to the burial place of Dr. John W. Seely, pioneer Ohio physician and first resident physician in the present Trumbull County. A biographical sketch of Dr. Seely was prepared by Dr. James J. Tyler, chairman of the Society's Sesquicentennial

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1. Osborne, T. B. and Mendel, L. B., J. Biol. Chem. 17:325, 1914.
2. Rose, W. C., Physiol. Rev. 18:109, 1938.
3. Wolpe, Leon Z. and Silverstone, Paul C., J. Pediat. 21:635, 1942.
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5. Schoenheimer, R., Ratner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.

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Committee and distributed as part of the program.

Ceremonies at the burial plot consisted of the following features: Invocation and benediction by the Rev. Preston S. Hyde; tribute to Dr. Seely by Dr. Tyler; remarks by Judge G. H. Birrell, chairman of the Trumbull County Sesquicentennial Committee; placing of wreath by Dr. E. W. Westbrook, president of the Society.

Activities of Woman's Auxiliary . . .

By MRS. EDWARD L. VOKE, Chairman, Pub'icity Committee, 243 Hampshire Road, Akron 13, Ohio

President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House
President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13
Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester
Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge
Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House
Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima
Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

DELAWARE

The Delaware County Auxiliary held its last meeting at the home of Mrs. George Parker. It was a luncheon meeting. The new president, Mrs. Edward Jenkins, presided and announced her committees: Mrs. George Blydenburgh, Mrs. Tennyson Williams and Mrs. Don Gantt, program; Mrs. George Parker, nurse recruitment; Mrs. Harold Davis, legislation; Mrs. M. W. Livingston, *Today's Health*; Mrs. Chester Theiss, and Mrs. Wray Davies, publicity; Mrs. Douglas Smith, historian; and Mrs. E. V. Arnold, sales tax stamps.

A letter was read from Mrs. A. R. Callander, who is now in Bad Nergentheim, Germany.

GREENE

Mrs. Richard F. Kelly, Xenia, is the new president of the Auxiliary to the Greene County Medical Society for the 1953-54 season. She succeeds Mrs. L. W. Sontag, at whose home the election meeting took place. Other officers elected were Mrs. S. C. Ellis, president-elect; Mrs. Gordon E. Savage, secretary; and Mrs. Paul F. McQuiggan, treasurer. The officers were installed by Mrs. Paul D. Espey of Xenia, past-president.

Reports of the State meeting in Cincinnati were given by Mrs. H. C. Messenger and Mrs. Kelly. The group was honored by having Mrs. Sontag serve as chairman of the Resolutions Committee and also as a moderator of the panel discussion on *Today's Health*. It was voted to make funds available to the practical nurses' course at Greene Memorial Hospital.

At the conclusion of the meeting, tea was served by Mrs. Sontag, assisted by Mr. P. B.

New Body Care for Happier Pregnancy

OBstetrical consideration of striation is a matter of just as much interest today as in olden days. The difference lies in prescription. The awareness of external body care was expressed by Dr. Jacques Guillemau, a great French obstetrician in his day, who published his book "Childbirth or The Happy Delivery of Women" in 1609. On body care during pregnancy he said:

". . . and about the third or fourth month, when she feeles herselfe quicke, about which time her belly begins to swell and grow big, she must wear a swathe (made fit for the purpose) to support her belly, being first annointed with the Liniment or Pomade, which she shall continue till the ninth month, to keep her belly from being full of knottie and broken vaines, furrowed and wrinkled, making grow deformed, unseemely, and hanging downe lower than is fit, which hapneth by reason of the great burthen and weight of the child, that stretcheth and inlargeth the skinne thereof."

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What alchemy formulated in those days and what the modern laboratory produces today are two different things, however concurrent the objectives are. We, therefore, commend these latest, medically approved formulations of Marion Phillips' Aids to necessary body care and a happier pregnancy.

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Wingfield and Mrs. H. M. Berley of Yellow Springs. At a recent meeting of the Greene County Auxiliary, scholarship awards of $100 each were made to two high school senior girls who plan to enter nurses training and an award of $200 went to a Xenia student nurse to continue her training.

Recipients of the awards were Miss Katryn Daines and Miss Thelma Newsome, and Miss Martha Chamblis. The awards were announced at a tea at the home of Mrs. Harold E. Ray, Old Springfield Pike, chairman of the nurse recruitment project. Prospective student nurses of Xenia and Greene County high schools were guests at the tea. Mrs. Ray explained the project in a broadcast over WJEL, Springfield, and Mrs. Sontag announced the awards. Miss Miriam E. Ray, director of nurses at Greene Memorial Hospital, and Miss Sarah Stokes, supervisor of nurses of the Public Health Department, spoke to the students about nursing.

Mrs. Kelley, the new president, and Mrs. Sontag, the retiring president, presided at the tea table, and the assisting hostesses were Mrs. H. C. Schick, and Mrs. Harvey B. McClellan.

HAMILTON

Mrs. William H. Lippert, retiring president of the Woman's Auxiliary to the Hamilton County Medical Society, entertained at a delightful luncheon at her home the last of May. Her guests included members of her board and committee chairman who served with her and those who will serve with the new president, Mrs. Robert H. Kotte.

The home of Mrs. Robert H. Kotte, new president of the Woman's Auxiliary to the Hamilton County Medical Society, was the scene of the busy get-to-gether recently. Many plans for the coming year were discussed by the new board members and standing committee chairmen. In addition to the new president, the new officers are Mesdames John G. Fleming, president-elect; J. Sterrett Caldwell, vice-president; A. J. Huesman, recording secretary; Roy L. Kile, corresponding secretary; Calvin F. Warner, treasurer; and William H. Lippert, past-president. Directors for the organization are Mesdames Phillip F. Pogue, Virgil D. Hauenstein and E. C. Elsey.

Chairmen of standing committees appointed by the president are Mesdames Harry L. Claassen, volunteer projects; Kent E. Martin, hospitality; Edward L. Dulle, radio and visual education; Richard D. Bryant, finance; I. C. Sharon, historian; Charles H. Moore, *Today's Health* and Bulletin; Carl F. Wagner, legislation; Byron E. Boyer, Philanthropy; Richard W. Vilter and Robert E. Slemmer, public relations; Carl H. Wendel, publicity; John A. Fisher, telephone; Earl C. Van Horn, ways and means; Raymond L. Hilsinger, courtesy. In addition to being presi-

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dent-elect, Mrs. John G. Fleming assumes the duties of the membership chairman.

The Woman's Auxiliary to the Hamilton County Medical Society was represented at the National Meeting of the American Medical Association held in New York City by Mesdames Paul M. Woodward, Barnet R. Sakler, Clyde M. Dummer, Lloyd E. Larrick, Roy L. Kile, Joseph E. Ghory, Charles Sabastian, F. Paul Duffy, and Robert Green.

LUCAS

Recently, the Lucas County Auxiliary delivered posters to industrial plants for the Civil Defense show in the Glass Bowl at the University of Toledo. Mrs. Roscoe H. Snyder is chairman of the Civil Defense. She was assisted in placing the posters by Mrs. Fred M. Douglass, Sr., chairman of Public Relations.

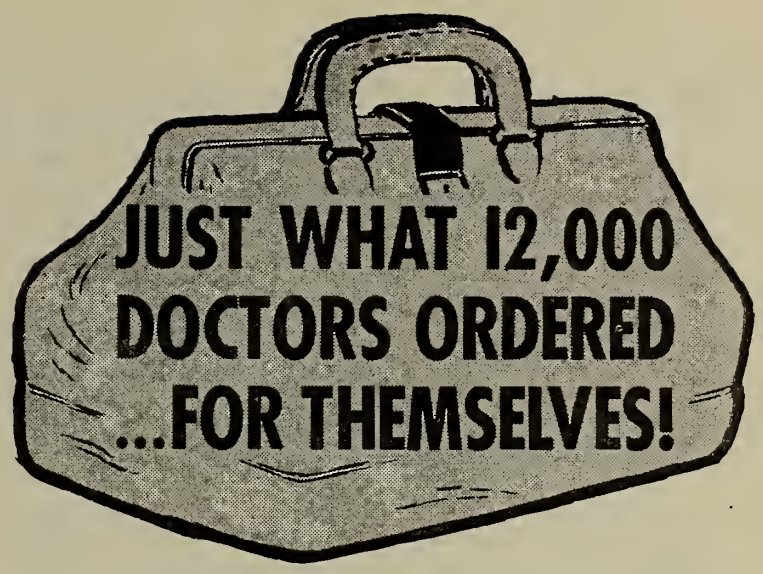
Mrs. Boni Petcoff, president of the Lucas County Auxiliary, entertained the officers of the group for luncheon at her home, 1930 Mt. Vernon Road, Toledo. She reported on the recent meeting of the A. M. A. Auxiliary in New York City. Others who attended the New York meeting were Mrs. E. Benjamin Gillette, a national director of Auxiliary, Mrs. A. Paul Hancuff, president-elect of the State Auxiliary, Mrs. Norman B. Muhme, and Mrs. John Gardiner.

Mrs. Arthur W. Hemphill and Mrs. Herbert C. Weller are chairmen of the Auxiliary's exhibit at the Sesquicentennial Show.

On June 30th in Heather Downs Country Club, Mrs. Petcoff entertained her executive board and the newly appointed chairmen of standing and special committees.

Plans for the Lucas County Fair to be held August 6 through 9 were discussed. Chairmen of the standing committees are as follows: Mesdames A. Paul Hancuff, finance; Wendell W. Green, legislative; Mrs. Edward L. Burns, membership; C. J. A. Paule, chairman, program; Norman B. Muhme, co-chairman, program; Carl A. Dreyer, publicity; Fred M. Douglass, Sr., and George H. Lemmon, public relations; W. LeRoy Bryant, radio and visual education; R. H. Snyder, Civil Defense; A. J. Kuehn, day care advisory; William M. Mewborn, social activities; R. P. Whitehead, Jr., study groups; and Davis L. Friedman, *Today's Health*.

Special committee chairmen are Mrs. J. B. Hirsch, credits and awards; Mrs. A. W. Hemphill, Mrs. Herbert Weller, Fair project; Mrs. Harold Shapiro, fund raising; Mrs. Robert F. Slotterbeck, Mrs. Richard G. Hotz, health; Mrs. Warren A. Baird, historian; Mrs. E. Benjamin Gillette, library; Mrs. Myron G. Means, nurse recruitment; Mrs. Howard Parkhurst, telephone; Mrs. James E. Mullen, yearbook; Mrs. John E.

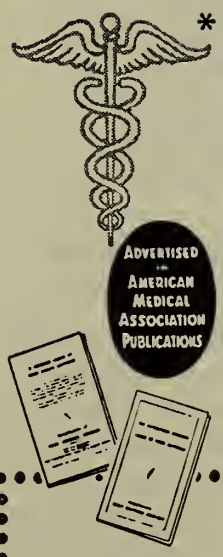




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Buck, Mrs. Hazen L. Hauman, Mothers' March on Polio.

Newly created committee chairmen are Mesdames Henry Brunsting, Wallace Morton, Community Chest; E. A. Ockuly and Berman Dunham, City of Toledo Woman's Traffic Council.

In a recent Sunday edition of the *Toledo Blade*, Mrs. A. Paul Hancuff, the president-elect of the State Auxiliary, was lauded as a club leader and praised for her long time activities in health work and other fields.

SUMMIT

The Summit County Auxiliary is very gratified to announce that for the second year it has been invited by the United Community Council to co-sponsor a "Hobby Show for Oldsters." Last year, this show was highly successful, attracting over 7,000 people. Mrs. Arthur Dobkin, president-elect of the Auxiliary, is the 1953 chairman of the "Hobby Show for Oldsters."

New Members of O.S.M.A.

Following are the names of new members of the Ohio State Medical Association since June 30, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY
Furman, Robert A., Cleveland
Hines, Clifton R., Cleveland
Krompaszky, Tibor, Cleveland
Rank, Robert K., Cleveland
Ralston, Robert E., Cleveland
Welty, Myron J., Berea

FRANKLIN COUNTY
Bethel, Raymond W., Columbus
Dierker, Frederick W., Columbus
Hanson, Chester A., Jr., Columbus
Mitchell, Howard R., Jr., Columbus
Silva, Charles J., Columbus
Todd, William E., Columbus
Watkins, Paul W., Columbus

HAMILTON COUNTY
Richards, Warren L., Cincinnati

LORAIN COUNTY
Altier, Samuel L., N. Ridgeville

MAHONING COUNTY
Thanos, John N., Campbell

PORTAGE COUNTY
Weiss, Ernest, Kent

ROSS COUNTY
Thornburgh, David, Chillicothe

WAYNE COUNTY
Stewart, William F., Rittman

Dr. Kiefer Named Medical Director Of National Insurance Society

Dr. Norvin C. Kiefer, former Ohioan, has been named chief medical director of the Equitable Life Assurance Society of the United States.

A practitioner in Geneva, Ohio, from 1931 to 1945, Dr. Kiefer was commissioned in the U. S. Public Health Service and in 1948 transferred to the Office of the Surgeon General and placed in charge of a new program of Health Emergency Planning. A year later he was made director of the Medical Services Division of the National Security Resources Board. Since 1951, he has been director of the Health and Special Weapons Defense Division of the Federal Civil Defense Administration.

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Pulmonary Diseases Course . . .

O.S.U. College of Medicine, Tuberculosis Organizations and State Association Combine Forces To Sponsor Comprehensive Program

SEPTEMBER 10 has been set as the deadline for registering in the special postgraduate course in pulmonary diseases to be given at Ohio State University College of Medicine and the Neil House in Columbus, September 25 and 26. The course is sponsored jointly by the O. S. U. College of Medicine, the Ohio Trudeau Society, the Ohio Tuberculosis and Health Association and the Ohio State Medical Association.

It has been approved for nine hours credit by the Ohio Academy of General Practice.

Hotel Reservations are to be arranged directly with the hotel of the registrant's choice. Course reservations may be made by using the accompanying coupon on this page. The coupon should be mailed as indicated on it and accompanied by the registrant's check for $15. A complete program, with a similar coupon, has been mailed to members of the Ohio State Medical Association. The complete program also was printed in the June issue of *The Journal*, page 552.

As an additional attraction, arrangements have been made to secure a block of seats for the Ohio State-Indiana football game at 2 p. m. on Saturday, following adjournment of the course. An additional amount of $3.50 per ticket should be included with the registration fee for those who wish to attend the game.

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(Includes Banquet Ticket)

..... Extra Banquet Tickets @ $5.00 .....

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Ohio State University vs. Indiana

..... Football Tickets at $3.50 .....
(Tickets will be held in your name at the Registration Desk

Total Enclosed .....

Mail Your Application and Make Check Payable to:

H. G. Howson, Treasurer
Ohio Tuberculosis Hospital
Columbus 10, Ohio

Ohio State Heart Association Announces Current Officers

Dr. Bernard A. Schwartz of Cincinnati was re-elected president of the Ohio State Heart Association at its recent Annual Meeting held in Cincinnati. Dr. R. W. Kissane of Columbus was made president-elect. Other officers were Irving B. Hexter, Cleveland, vice-president; Lewis A. Seikel, Akron, secretary; Charles W. McCoy, Columbus, treasurer. Dr. A. Carlton Ernstene, Cleveland, Mrs. O. W. Haulman, Youngstown, Dr. Maurice A. Schnitker, Toledo, and Dr. J. Paul Sauvageot, Akron, were made members of the Executive Committee, in addition to the officers.

The offices of the Ohio State Heart Association, which is the Ohio affiliate of the American Heart Association, are located at 55 East State Street, Columbus.

Proportion of Married Among Youth Now Is Highest on Record

Americans are marrying earlier in life. According to the most recent data available, nearly 17 per cent of all girls at ages 15 to 19 are married now or have been married, as compared with only 12 per cent in 1940. At ages 20 to 24 the current ever-married proportion is 69 per cent as compared with 53 per cent in 1940.

For males the trend to early marriages is equally marked. Currently almost half of the men at ages 20 to 24 are or have been married, as compared with only 28 per cent in 1940. Even in the older age groups, the statisticians point out, the married constitute a notably larger proportion of the population than was the case prior to World War II.—Metropolitan Life.

Buckeye Notes . . .

Butler—A community celebration was held on June 14 in honor of Dr. John A. Reed who has practiced for 50 years. He was presented a watch inscribed "To Dr. J. A. Reed for faithful service from a grateful community, 1903-1953." Present for the celebration with Dr. and Mrs. Reed were Dr. Betty Reed, their daughter; Dr. Myron Reed, their son, and Dr. Pat Test, son-in-law. Unable to be present was another daughter, Dr. Barbara Reed.

Cleveland—Dr. Guy Williams, medical superintendent of the Hawthornden State Hospital, was honored at an open house at the hospital for his service during 50 years of practice, all of it with the mental institutions of Ohio.

Cleveland—Dr. Allan C. Barnes was guest speaker at a luncheon for nurses interested in maternity, in conjunction with the biennial national convention of the National League for Nursing. Dr. Barnes, formerly head of the Department of Obstetrics and Gynecology, Ohio State University, now heads the same department at Western Reserve University.

Columbus—Dr. Richard L. Meiling, associate dean of the Ohio State University College of Medicine, and Treasurer of the Ohio State Medical Association, addressed a meeting of the Woman's Luncheon Club, on the subject of the O. S. U. Health Center.

Dayton—Dr. Robert Stafford took office as chief of staff of the College Hill Hospital in June. Dr. Orville Wright was elected to succeed him as chief of staff in June 1954.

Delphos—Dr. and Mrs. John F. Ockuly observed their golden wedding anniversary on June 21. They are the parents of four sons, all of whom are doctors of medicine.

Montpelier—Dr. Victor Boerger, Edgerton, was elected chief of staff of the Williams County General Hospital.

New Bremen—Dr. Ferdinand F. Fledderjohann in June attended the reunion of the medical class of 1903 at Jefferson Medical College, Philadelphia. He has been practicing in the Auglaize County community since that year.

The Plains (Athens County)—Dr. Lorenzo D. Nelson, practicing physician in the community since 1910 was honored at a special program given by the people of the community in recognition of his services.

Youngstown—Dr. Hugh H. Hussey, associate professor of medicine, Georgetown University School of Medicine, Washington, D. C., was guest speaker at the annual reunion of the St. Elizabeth Hospital Ex-Intern Association.

Cook County Graduate School of Medicine

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, two weeks, starting Sept. 14, Sept. 28, Oct. 12. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting Oct. 26. Surgical Anatomy & Clinical Surgery, two weeks, starting Aug. 17, Nov. 9. Gallbladder Surgery, ten hours, starting Oct. 26. General Surgery, one week, starting Oct. 5. Surgery of Colon & Rectum, one week, starting Sept. 21. Basic Principles in General Surgery, two weeks, starting Sept. 21. Thoracic Surgery, one week, starting Oct. 12. Esophageal Surgery, one week, starting Oct. 19. Breast & Thyroid Surgery, one week, starting Oct. 26. Fractures & Traumatic Surgery, two weeks, starting Oct. 26.

GYNECOLOGY—Intensive Course, two weeks, starting Sept. 21. Vaginal Approach to Pelvic Surgery, one week, starting Aug. 31.

OBSTETRICS—Intensive Course, two weeks, starting Oct. 5.

DERMATOLOGY—Intensive Course, two weeks, starting Oct. 19.

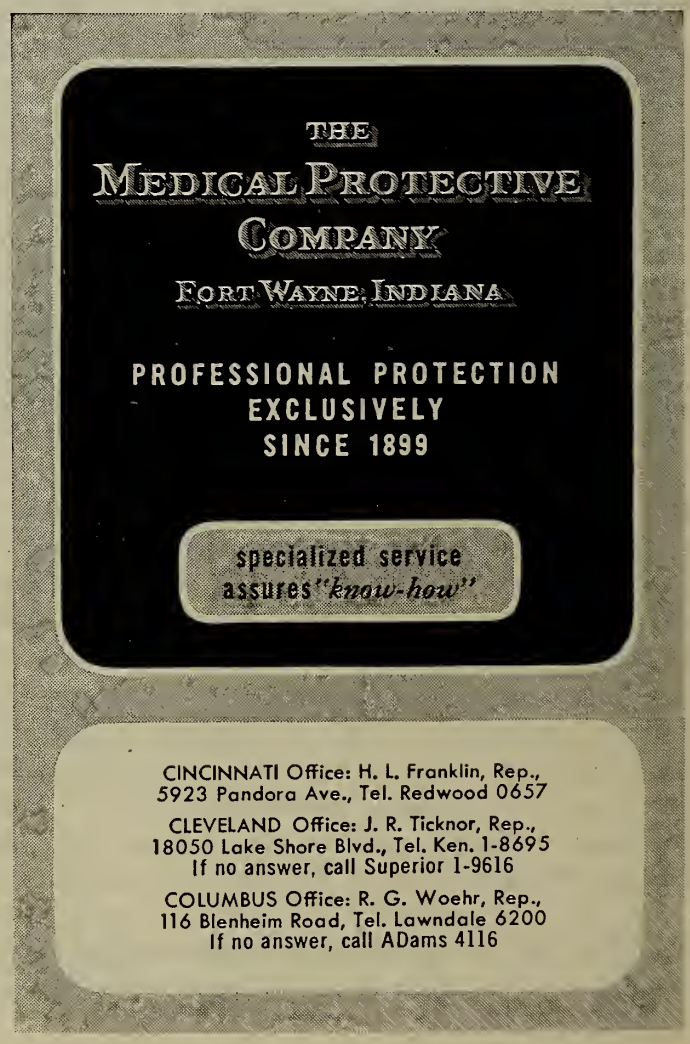
MEDICINE—Electrocardiography & Heart Disease, two weeks, starting Oct. 12. Intensive General Course, two weeks, starting Sept. 28. Gastroenterology, two weeks, starting Oct. 26. Allergy, one month and six months, by appointment.

CYSTOSCOPY—Ten-Day Practical Course, starting every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 26.

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Eighth District Doctors Will Meet At McConnelsville, August 27

The annual meeting of the Eighth District Medical Society will be held at Rocky Glen Sanatorium, McConnelsville, on Thursday, August 27, beginning at 1:30 p. m.

There will be a short business meeting and election of officers for the coming year. Dr. Louis Mark, medical director and his staff of the Rocky Glen Sanatorium will be hosts to visiting doctors.

The scheduled program is announced as follows:

1. "Cobalt Teletherapy Treatment in Malignancies," Dr. William P. Smith, chief of staff, White Cross Hospital, Columbus.
2. "Experiences with Hystoplasmosis," Dr. Samuel Saslaw, assistant professor of medicine and bacteriology, Ohio State University, Columbus.
3. "Pneumoconiosis in Soft Coal Miners," Dr. Louis Friedman, consultant in industrial medicine, Birmingham, Ala.
4. "Intermittent Positive Pressure Treatment for Bronchospasms, Emphysema and Pneumoconiosis," Dr. Louis Mark, medical director of Rocky Glen Sanatorium and chief of Chest Department, White Cross Hospital.

No Scientific Merit Found In Hett So-called "Cancer Cure"

A number of members have written to the Columbus Office recently inquiring about one Dr. J. E. Hett of Windsor, Ontario, and his so-called "cancer cure." Apparently Hett has been sending advertising material to Ohioans who in turn have asked their physicians for the low-down.

It is suggested that physicians advise those who ask about Hett that so far competent investigators have failed to find any scientific merit in his procedures for the diagnosis and cure of cancer. The record shows that in April, 1952, Hett's license to practice medicine in Ontario was revoked for several reasons.

Privileged Communication Decision

Ohio Supreme Court, in the case of Strizak vs. Industrial Commission of Ohio, held that in an action, the purpose of which is to recover compensation or damages for a physical injury, a physician who has treated plaintiff professionally for such injury is not precluded by Section 11494, General Code, relating to privileged communications, from giving expert testimony in response to proper hypothetical questions, provided that in answering the questions he disregards what he learned and observed while attending the patient and his own opinion formed thereon. (Case No. 33198, decided May 20, 1953.)

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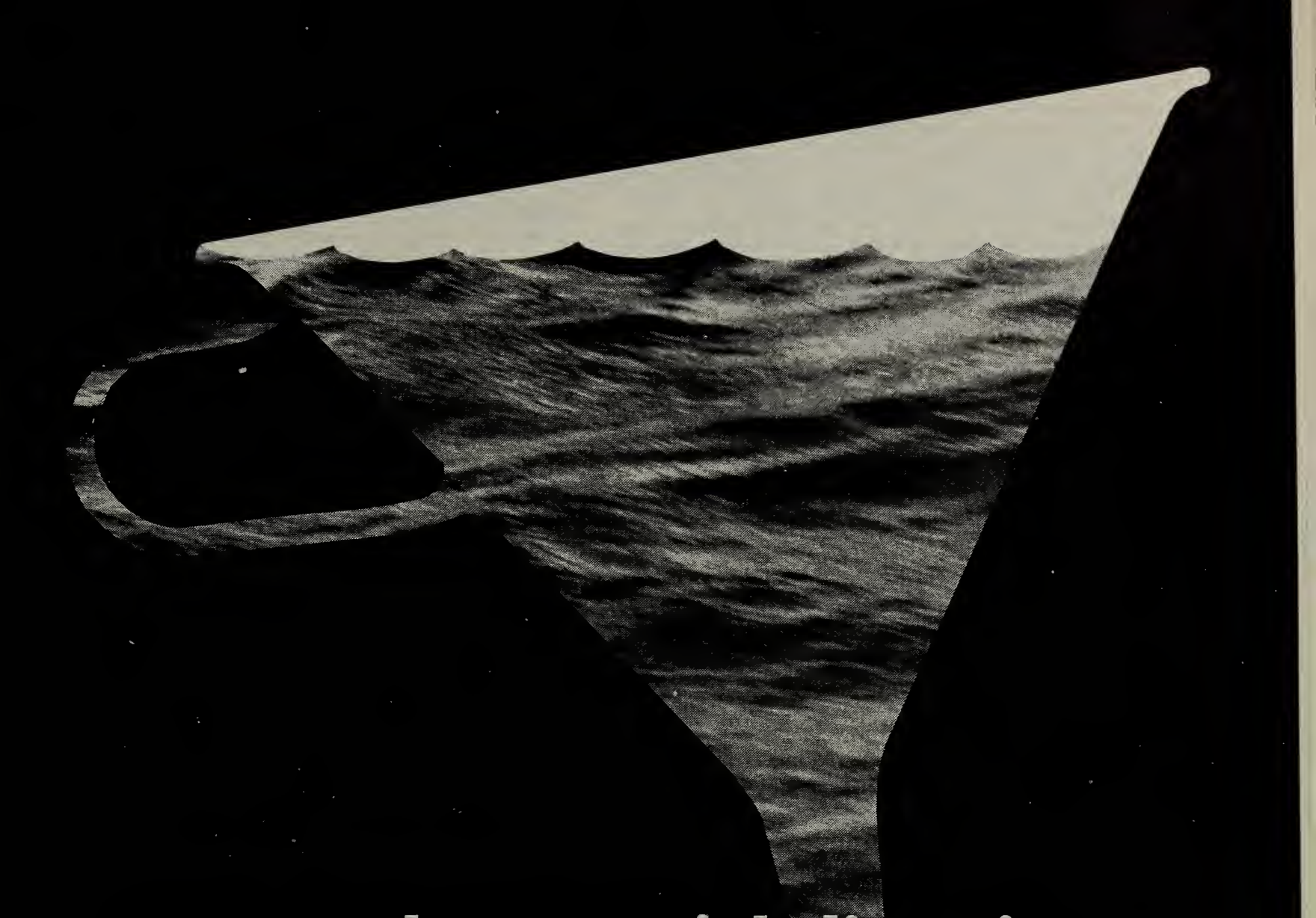
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BUTLER—Willis F. Hume, President, Hamilton; Hazelett A. Moore, Secretary, Oxford. 4th Wednesday, monthly.

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CLINTON—James H. Frame, President, Wilmington; Robert E. Suer, Secretary, Wilmington. 1st Tuesday, monthly.

HAMILTON—Dale P. Osborn, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 371 Doctors Bldg., Cincinnati. 2nd and 4th Tuesday, monthly, except June, July and Aug.

HIGHLAND—Joshua B. Glenn, President, Greenfield; George L. Morris, Secretary, Hillsboro. 1st Wednesday, monthly.

WARREN—Rossell M. Brewer, President, Lebanon; O. W. Hoffman, Secretary, Franklin. 1st Tuesday, monthly.

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DARKE—Emmett W. Arnold, President, New Madison; Maurice M. Kane, Secretary, Greenville. 3rd Tuesday,

GREENE—S. C. Ellis, President, Xenia; Charlotte Ames, Secretary, Xenia. 2nd Thursday, monthly.
lotte Ames, Secretary, Xenia. 2nd Thursday, monthly.

MIAMI—Hugh Wellmeier, President, Piqua; Dale Hudson, Secretary, Piqua. 1st Friday, monthly, except Aug. and Sept.

MONTGOMERY—Robert C. Austin, President, Dayton: Mr. Robert F. Freeman, Executive Secretary, Fidelity Medical Bldg., Dayton. 1st Friday, monthly, except July, Aug., Sept.

PREBLE—A. L. Ross, President, West Alexandria; Joseph R. Williams, Secretary, Eaton. No regular meeting date.

SHELBY—John Kerrigan, President, Sidney; George Schroer, Secretary, Sidney. 2nd Tuesday, monthly.

THIRD DISTRICT

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HANCOCK—John F. Roth, President, Findlay; Ralph E. Rasor, Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—R. G. Schutte, President, Kenton; Robert Shultz, Secretary, Kenton. 2nd Tuesday, monthly.

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MERCER—J. J. Otis, President, Celina; John W. Chrispin, Secretary, Rockford. 4th Thursday, monthly.

SENECA—Walter A. Daniel, President, Tiffin; John E. Roose, Secretary, Tiffin. 3rd Tuesday, monthly.

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FOURTH DISTRICT

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PUTNAM—Joseph J. McHugh, President, Ottawa; Walter W. Donahue, Secretary, Leipsic. 1st Tues., monthly, except June, July, Aug.

SANDUSKY—Howard A. Yost, President, Fremont; Leon H. Moore, Secretary, Fremont. 3rd Wednesday, monthly.

WILLIAMS—John Riesen, President, Bryan; Victor L. Boerger, Secretary; Edgerton. Last Tues., monthly.

WOOD—F. F. Price, President, Stony Ridge; Donald L. Gamble, Secretary, Bowling Green. 3rd Thurs., monthly.

FIFTH DISTRICT

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CUYAHOGA—John H. Budd, President, Cleveland; Mr. H. Van Y. Caldwell, Executive Secretary, 2009 Adelbert Rd., Cleveland. 2nd Tuesday.

GEAUGA—Shigeki Hayashi, President, Chesterland; Alton W. Behm, Secy., Chardon. 2nd Friday, April to Dec.

LAKE—G. Robert Smith, President, Painesville; James G. Powell, Secretary, Painesville. 3rd Tuesday, monthly.

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COLUMBIANA—Paul W. Conrad, President, Leetonia; William F. Stevenson, Secretary, Salem. 3rd Tuesday, monthly.

MAHONING—Vernon L. Goodwin, President, Youngstown; Mrs. Mary B. Herald, Executive Secretary, 125 W. Commerce St., Youngstown. 3rd Tuesday, monthly.

PORTAGE—Albert L. Tsai, President, Ravenna; Myrtle Collins-Dineen, Secretary, Kent. No regular meeting date.

STARK—Clair B. King, President, Canton; Mr. E. M. Sprunger, Executive Secretary, 400-4th St., N. W., Canton. 2nd Thursday.

SUMMIT—Millard C. Beyer, President, Akron; Mrs. Betty J. Weaver, Office Secretary, 437 Second National Bldg., Akron. 1st Tuesday, monthly.

TRUMBULL—Edwin R. Westbrook, President, Warren; George A. Sudimack, Secretary, Warren. 3rd Wednesday.

SEVENTH DISTRICT

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CARROLL—Charles H. Dowell, President, Carrollton; Robert H. Hines, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Norman L. Wright, President, Coshocton; H. W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—Richard W. Weiser, President, Jewett; Donn L. Tippett, Secretary, Cadiz. Meetings called by President.

JEFFERSON—Laura K. Mesaros, President, Steubenville: Frances J. Shaffer, Secretary, Toronto. 2nd Tuesday, monthly.

MONROE—Byron Gillespie, President, Woodsfield; A. R. Burkhart, Secretary, Woodsfield. 2nd Wednesday, monthly.

TUSCARAWAS—Benjamin Pilloff, President, Uhrichsville; Elizabeth Rowland-Aplin, Secretary, Gnadenhutten. 2nd Thursday, monthly.

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ATHENS—Lawrence I. Goldberg, President, Athens: Charles R. Hoskins, Secretary, Athens. 2nd Tuesday.

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GUERNSEY—Howard F. Van Noate, President, Cambridge: Reo M. Swan, Secretary, Cambridge. 1st Thursday.

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WASHINGTON—Richard R. Hille, Secretary, Marietta. 2nd Wednesday.

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JACKSON—Earl H. Stanley, President, Jackson; Robert E. Smith, Secretary, Oak Hill. 3rd Thursday, monthly.

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SCIOTO—Sol Asch, President, Portsmouth; Joseph T. Gohmann, Secretary, Portsmouth. 2nd Monday, monthly.

VINTON—Herbert D. Chamberlain, Secretary, McArthur. No regular meeting date.

TENTH DISTRICT

DELAWARE—George J. Parker, President, Delaware; Francis M. Stratton, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—R. D. Woodmansee, President, Washington C. H.; J. O. Stoffel, Secretary, Washington C. H. 1st Friday, monthly.

FRANKLIN—Robert C. Kirk, President, Columbus; Mr. Stanley R. Mauck, Executive Secretary, 79 E. State St., Columbus. 3rd Monday.

KNOX—Joseph W. Allman, President, Centerburg; James C. McLarnan, Secretary, Mt. Vernon. No regular meeting date.

MADISON—J. William Hurt, President, West Jefferson; Sol Maggied, Secretary, West Jefferson. 1st Wednesday.

MORROW—Stanley L. Brody, President, Cardington; David James Hickson, Secretary, Mt. Gilead. 4th Tuesday.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Year Book of Obstetrics and Gynecology 1952, Edited by J. P. Greenhill, Jr., M. D., ($5.50. *Year Book Publishers, Chicago, Ill.),* reviews again in a most satisfactory manner the significant advances in this field for the past year. It presents 555 pages of abstracted material with editorial comment.

Neomycin, Its Nature, Formation, Isolation, and Practical Application, by Selman A. Waksman, ($4.00. *Rutgers University Press, New Brunswick, N. J.).* This is the story of a new and useful antibiotic by the discoverer of streptomycin in his search for one that would overcome some of the limitations of his first discovery.

Psychoanalysis as Science, by E. Pumpian Mindlin, M. D., Ernest R. Hilgard, Ph. D., and Lawrence S. Kubie, M. D., ($4.25. *Stanford University Press, Stanford, Calif.).* These Hixon lectures attempt to evaluate psychoanalysis as a genuine body of knowledge whose alleged findings are valid. This attempt approaches the problem from the viewpoint of experimental psychology, the techniques of validation in psychoanalysis, and relation of the methodology used to the biological sciences.

Biochemistry of Disease, by M. Bodansky and Oscar Bodansky—this second edition by Oscar Bodansky, M. D., ($12.00. *The Macmillan Company, New York 11, N. Y.).* The fact that the text is arranged according to clinical entities makes this work especially valuable to the practicing physician.

Marriage, by Earl Lomon Koos, ($5.50. *Henry Holt & Company, 383 Madison Ave., New York 17, N. Y.).* This is the latest college text patterned after the first written by Groves just 20 years ago. It is built on the sound historical concept that it is the experience of past generations—distilled and clarified by research and interpretation which gives to the new generation a basis upon which to build its own life.

School Health Problems, by L. B. Chenoweth and T. K. Selkirk, ($4.00. 4th edition. *Appleton-Century-Crofts, Inc., New York 1, N. Y.),* has been brought up to date. Your reviewer notes with amazement that the authors add fluorine as a trace element essential for tooth development. While it is generally recognized that fluorine when used as a medicine does so harden some 40 per cent of the teeth of a growing child as to prevent their decay, yet there is no evidence as yet that fluorine is an essential element to any plant or animal. On the other hand, there is an abundance of evidence to show that even in very dilute amoun's the element is a strong inhibitor of many cellular enzymes—notably the alkaline phosphatases.

Chemicals in Foods and Cosmetics. Being a record in four parts of the hearings before the select committee to investigate the use of chemicals in foods and cosmetics, House of Representatives of the 82nd Congress. *(Supt. of Documents, U. S. Government Printing Office, Washington 25, D. C.).* Here is a set of testimony with which every physician should be familiar. With our farmers using over a billion pounds of insecticides on food products, stilbestrol coming in our artificial capons, DDT pervades the fat of all of us. It is time we should inform ourselves about these things and some 500 and more chemicals used as additives to our foods—many of which are antagonistic to many of the vitamins and to the enzymes in which they are component parts.

The Rutgers Food Saver, by Walter A. Maclinn, Ph. D., ($2.95. *Rutgers University Press, New Brunswick, New Jersey).* This is a book to teach us how to use food today for tomorrow so that there shall be no waste. As the pressure of population and Kenysian economics will make this pressure greater, the solution of this problem is a must in every home if we are to maintain any semblance of health.

Modern Treatment—A Guide for General Practice, by fifty-three authors, edited by Austin Smith, M. D., and Paul L. Wermer, M. D., ($20.00. *Paul B. Hoeber, Inc., Medical Book Dept. of Harper & Bros., New York, N. Y.),* a huge volume of some 1100 pages. It will prove helpful in evaluating current methods for one's own practice.

Food-Born Infections and Intoxications, by Fred W. Tanner, Ph. D., and Louise P. Tanner, Ph. D., ($12.00. Second Edition. *The Garrard Press, Champaign, Ill.).* This subject is of relatively little importance until there is an outbreak in one's own home or neighborhood, then it assumes great importance. Usually one can't find any literature to help. This book is designed to do just that if it is on the library shelf.

The White Plague: Tuberculosis, Man and Society, by Dr. Rene and Jean Dubos, ($4.00. *Little, Brown & Co., Boston 6, Mass.).* Here is told the thrilling story of the men who have fought tuberculosis. They treat tuberculosis as a social disease and behind all this they give an adequate description of the disease through the ages. The senior author is the distinguished

editor of *The Journal of Experimental Medicine* while Jean Dubos is a bacteriologist whom we in Ohio can claim as our own as a graduate of Ohio State University.

Tuberculosis, by Saul Solomon, M. D., ($3.50. *Coward-McCann, Inc., New York 16, N. Y.),* is one of the publisher's health series. It is designed to present current knowledge and recent advances in the care and cure of this disease for the general reader.

Poliomyelitis—Papers and Discussions Presented at The Second International Poliomyelitis Conference, ($7.50. *J. B. Lippincott Company, Philadelphia, Pa.).* A comprehensive coverage of the subject, especially the progress made in the last four years.

Applied Physiology, by Samson Wright, M. D., ($9.00. 9th Edition. *Oxford University Press, New York 11, N. Y.),* is virtually a new book. More than half the text has been rewritten and the rest carefully revised. The opening chapter on the constancy of the internal environment is worth the price of the book. This old concept has been integrated with the findings of modern chemistry and physics.

Roentgenology in Obstetrics and Gynecology, by William Snow, M. D., ($10.50. 2nd Edition. *C. C. Thomas, Springfield, Ill.),* is based on factual data largely from the author's own wide experience. The book teaches how to analyze the x-ray findings from the film study alone and then how to correlate them with other clinical data. This is an atlas of the soft parts as well. The "Cautions, Safeguards and Specific Directions" make the book invaluable to every x-ray specialist and to the residents' library on Obstetrics and Gynecology in every hospital.

Sex and Marriage, Eros in Contemporary Life, by Havelock Ellis, ($3.00. *Random House, New York 22, N. Y.).* This classic has been edited by John Gawsworth, F. R. S. L., for lay consumption. For all who have never read his "General Preface" which Ellis wrote in 1897 to the first volume of his studies, it is here reproduced for this generation's information and for those of this reviewer's generation to enjoy its sincerity.

Courtship and Love, by William S. Sadler, M. D., ($3.50. *The Macmillan Company, New York 11, N. Y.).* The author, a well known psychiatrist, especially interested in this field, gives advice and counsel to young people respecting their premarital love life.

Glands—Sex and Personality, by Herman H. Rubin, M. D., ($2.95. *Wilfred Funk, Inc., New York 36, N. Y.),* a popular presentation of the hormones and their function in building our personalities.

Patterns of Psychosexual Infantilism, by Wilhelm Stekel, M. D., ($5.00. *Liveright Publishing Company, New York 16, N. Y.).* A discussion of one of the most baffling forms of sexual behavior, of man's desire for eternal youth and the ways in which this desire finds expression.

The Marriage Counselor, by David Loth, ($2.00. *Greystone Press, New York 13, N. Y.).* An intimate guide for women to all the problems they will face in courtship and marriage.

How to Hold Your Husband, by John Thomas Gill, Ph. D., ($2.00. *Dorrance & Company, Philadelphia 6, Pa.),* is a frank psychoanalysis for happy marriage. Here teaching wives how to be congenial and compatible are the cardinal principles expressed.

The Sexually Adequate Male, by Frank S. Caprio, M. D., ($3.00. *The Citadel Press, New York 10, N. Y.),* a discussion of the physical and emotional causes of impotence, how they can be cured and a happy and successful marital relationship be achieved.

Sexual Adjustment in Marriage, by Henry Olsen, M. D., ($6.00. *Henry Holt and Company, 17, N. Y.),* is another good attempt at a complete medical and psychological guide to happy marriage. It is one of the largest and most detailed of the recent books in this field.

Mastering Your Disability, by Harold A. Littledale, ($2.75. *Rinehart & Company, New York 16, N. Y.),* has been written for the disabled by the disabled. We have all too few aids for the disabled when they leave the hospital. This book is specifically for the orthopedically injured but its philosophy and the author's own experiences will help any disabled person.

Circulatory Dynamics—Physiologic Studies, by Carl J. Wiggers, M. D. ($4.00. *Grune & Stratton, Inc., New York 16, N. Y.,* is the publisher of this Number 4 in the Modern Medical Monograph series.) It is a collection of discourses which the professor of psychology at Western Reserve University has recently given on the experimental aspects of the subject.

The Pathogenesis and Treatment of Thrombosis, by Irving S. Wright, M. D., ($3.00. *Grune & Stratton, Inc., New York 16, N. Y.),* is the publisher's Medical Monograph Number 1. With our concern over the two great killers of mankind, atherosclerosis and thrombosis, this lecture of 75 pages based on the Annual George E. Brown Memorial Lecture is most welcome.

Public Speaking for The Professions and Clubs, by Samuel Kahn, M. D., ($3.00. *Greenburg Publishers, New York 22, N. Y.),* is a psychological and practical approach to dynamic public speaking for business and professional people. Most physicians need training in this field. Some of the physicians in New Orleans are organized into a Toastmaster's Club. That is a good idea and so will be the studying of this book.

Meat...

and the Diet after 50

Although caloric needs in the later decades of life lessen with decreasing physical activity and diminishing metabolic rate, clinical observations[1] corroborated by experimental studies[2] show that protein needs of the aging organism continue at the levels of adequacy in earlier years.[3] For avoidance of protein deficiencies, which the aged are prone to develop,[4] the protein quota of the diet of persons over fifty should be more liberal than is often the practice.[5] In providing this quota, lean meat may well be one of the protein foods of the daily diet.

In the years beyond fifty, as well as before, continuous adequate protein nutrition remains an absolute necessity for maintenance of a normal concentration of plasma proteins and, in turn, a normal osmotic pressure of the plasma.[6] Even more pronounced in the aged than in younger persons are the ill consequences of hypoproteinemia—edema, decreased resistance to generalized infection, retarded bone healing, and poor wound healing.[7] Furthermore, dietary protein is essential for the continuous chemical regeneration of cell protein in the prevention of abnormal tissue wasting, one of the most characteristic and obvious changes in the geriatric patient.[8]

But meat is much more than an outstanding protective protein food in the dietary of persons over fifty. It also supplies generous amounts of the B group of vitamins and of iron, phosphorus, and other essential minerals. In the well-balanced diet of the later years of life, meat is just as important for the maintenance of nutritional and physiologic well-being as it is during the earlier years of life.

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Bronchiogenic Carcinoma Simulating Virus Pneumonia

HARRY R. CUSTER, M. D., and KARL P. KLASSEN, M. D.

IT is the purpose of the following discussion to review the more common causes of delayed resolution of pneumonia and to present the diagnostic measures employed in making the differential diagnosis of virus pneumonia and bronchiogenic carcinoma.

In the past five years 117 patients with cancer of the lung entered the Medical Center at the Ohio State University. Before admission 26 were erroneously diagnosed as, and treated for, pneumonia over a protracted period. Only six cases, or 23 per cent, were resectable by that time. This mistaken and frequently fatal diagnosis can be eliminated only after the medical profession becomes aware of the pathogenesis and complications of cancer of the lung. We view with alarm the ever-increasing incidence as well as the inability to unmask the true nature of this disease.

It has become apparent that 75 to 80 per cent of carcinoma of the lung is seen in men and is the most common site of malignancy in males. Therefore we advocate that every man over 40 years of age with unexplained thoracic discomfort, persistent cough, hemoptysis, or recurrent virus pneumonia should be suspected of having pulmonary carcinoma.

DELAYED RESOLUTION

Delayed resolution or unresolved pneumonia is not the usual course of events in an otherwise healthy adult. However, there are certain agents which will produce this picture, some of which are Klebsiella pneumonia, Diplococcus pneumoniae-Type III, Streptococcus, Staphylococcus, Pasteurella tularensis, septic emboli, tuberculosis and viruses. Virus pneumonia is usually associated with considerable bronchitis and patches of pneumonitis which appear to change slowly and to migrate, with new areas appearing while others resolve.[1] Also, the patient appears more toxic than the x-ray would lead you to believe.

Pasteurella tularensis, Friedlander bacillus, and Diplococcus pneumoniae-Type III can be identified in the sputum. The patient with tuberculosis pneumonia will usually have a cough before the acute onset and there is less cyanosis, dyspnea and prostration than in the other forms. Diagnosis is usually made with serial x-rays and positive sputum. Pneumonia from septic emboii shows crops of pulmonary lesions, and the source is frequently evident, being osteomyelitis, thrombophlebitis, puerpural or postabortal pelvic infections.

Aspiration of foreign material will predispose to protracted pneumonitis. The most common offenders are infectious oral secretions, oil and food particles. The pneumonia is often seen

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following alcoholic intoxication, diabetic coma, hypoglycemia, cardiovascular accidents and epileptic attacks. Food may be aspirated in patients with cardiospasm and esophageal diverticula. Oil aspiration pneumonia is seen in infants and debilitated geriatric patients and the symptoms are usually mild.

The largest percentage of patients with unresolved pneumonia do not have normal bronchial drainage. The factors which inhibit bronchial drainage include upper respiratory obstruction, impaired ciliary action, impaired pulmonary mobility, extrinsic bronchial compression, bronchial stenosis and bronchial obstruction including carcinoma.

Upper respiratory obstruction may be caused by hypertrophy of the tonsils or carcinoma of the larynx. Impaired ciliary action is typified by bronchiectasis which can be diagnosed by a bronchogram. The patient with marked emphysema, paralysis, or splinting of the diaphragm will have impaired pulmonary mobility.

The pneumonitis produced by extrinsic bronchial compression is usually due to enlarged peribronchial lymph nodes and presents itself as a middle lobe syndrome. Bronchial stenosis is commonly seen as the result of a foreign body, broncholith, tuberculous bronchitis or ulceration. The stenosis can be identified with bronchogram.

BRONCHIAL STENOSIS

Bronchiogenic carcinoma may at first produce bronchial stenosis and partial occlusion with associated pneumonia peripherally which will respond temporarily to antibiotic therapy. However, as the cancer grows the bronchus becomes completely obstructed resulting in recurrent pneumonitis or atelectasis which is mistaken for pneumonia. This is the type which is erroneously diagnosed as recurrent or virus pneumonia.

Bronchiogenic carcinoma may be present with all types of associated pulmonary pathology. Thus the diagnosis of other lung diseases does not exclude the presence of cancer. Primary carcinoma of the lung is not uncommonly seen in cases of bronchiectasis, extrinsic bronchial compression, pulmonary tuberculosis, metastatic cancer and primary and secondary lung abscess.

The diagnosis of bronchiogenic carcinoma necessitates a complete history, a thorough physical examination and a high index of suspicion. There are several diagnostic aids which are of value, namely, x-ray studies of the lung, the tracheobronchial tree, and pulmonary circulation. Bronchoscopy is routinely performed and finally exploratory thoracotomy may be necessary to ascertain the correct diagnosis.

The patient's history may reveal several very significant facts, such as an unexplained cough for more than two weeks; recurrent or unresolved pneumonia, especially in the same lobe or segment; pneumonia in an otherwise healthy patient; sudden onset of dyspnea without cardiovascular disease, especially with a unilateral wheeze and hemoptysis. Further findings may include deep-seated chest pain, sudden onset of bronchiectasis or a lung abscess, asthma beginning late in life, spontaneous serosanguineous pleural effusion, and unexplained paralysis of the diaphragm or vocal cords.

Occasionally the physical examination is completely unrevealing. However, there is usually evidence of recent weight loss. The neck may show several physical signs of bronchiogenic carcinoma including cervical lymphadenopathy, deviation of the trachea, and vocal cord paralysis. The thorax may exhibit decreased expansion. pleural effusion, atelectasis, consolidation, or elevation of the diaphragm.

USE OF X-RAYS

Much information can be acquired from diagnostic x-rays. Serial films of at least 10 days duration are much more informative inasmuch as the progress of the disease can be followed. If the pulmonary density progresses in an atelectatic fashion there is more apt to be some bronchial obstruction; if it shows honeycombing and a tendency to form an abscess it is more apt to be infectious. Usually primary lung infection clears in a lobular pattern and after the infection has cleared the patient should have follow-up x-rays to detect any change in the hilar shadows, which may be the first clue to the underlying pulmonary disease. X-rays will differentiate an expanding lesion from a contracting lesion.

Pneumonia is an expanding lesion and the trachea, bronchi, and mediastinum are apt to deviate away from the affected lung along with depression of the ipsilateral diaphragm. The interlobar fissures bulge away from the lesion. Carcinoma of the lung usually causes contraction of the tissues, and the trachea, bronchi, and mediastinum are pulled towards the affected side. The interlobar fissures are pulled towards the lesion and the ipsilateral diaphragm may be elevated.

Fluoroscopy is used to study the mechanics and physiology of the respiratory system. Minimal or partial bronchial obstruction will show a mediastinal shift under the fluoroscope which may not be evident by radiograms. Also diaphragmatic paralysis is apparent by this procedure.

Adequate bronchoscopy and bronchograms are considered imperative in most cases. Bronchoscopy allows direct visualization of the vocal cords, trachea, right and left main-stem bronchi and the orifices of the lobar bronchi, and fixation of the bronchi can thus be demonstrated. Distortion of the carina, tracheobronchial tree, and lobar bronchi orifices is a common finding. Occasionally the lesion can be visualized and biopsy taken. Bronchial lavage is performed and the material is examined for malignant cells, tubercle

bacilli and the predominant organism. However, the absence of malignant cells does not rule out the presence of bronchiogenic carcinoma. The bronchogram demonstrates distortion of the tracheobronchial pattern. Bronchial occlusion can be seen as well as the localization and extent of the lesion, and associated lung pathology is often detected.

ARTERIOGRAPHY

Keil and Schissel[2] found pulmonary arteriography useful in the differentiation of unresolved pneumonia and bronchial carcinoma. They state that increased or normal vascularity of the involved segment of the lung is a characteristic finding in unresolved pneumonia while decreased vascularity within and distal to the carcinoma was found in 92 per cent of the cases studied.

In some cases of early bronchiogenic carcinoma the diagnosis is not certain in spite of all efforts to detect the nature of the lesion. The history may be suggestive of a pulmonary malignancy and x-ray studies, bronchograms, and bronchoscopy may be noncontributory. Thoracentesis with examination of the fluid from a pleural effusion is apt to be negative. It is in these cases that the thoracic surgeon must rely on his clinical experience and knowledge. These are usually the early lesions which are most amenable to surgical cure but may be confused with localized tuberculosis.

Formerly intrathoracic surgery was contraindicated in patients suspected of having pulmonary tuberculosis because of the fear of dissemination. However, with the advent of present-day chemotherapy, surgery may be performed without undue risk and indeed surgical resection of localized tuberculosis is an accepted routine procedure. Therefore we advocate and advise an exploratory thoracotomy in all cases where bronchiogenic carcinoma cannot be ruled out. In an institution having competent anesthesiologists and thoracic surgeons, exploratory thoracotomy is no more hazardous than a comparable abdominal exploration. Occasionally with the lung exposed the thoracic surgeon may still be challenged to find a small, well hidden malignancy which is masked by massive infection.

CASE REPORTS

The following cases exhibit the danger of making a diagnosis of virus or recurrent pneumonia and the difficulties encountered in arriving at the diagnosis of bronchiogenic carcinoma.

Case 1. Admitted August 30, 1951.

Chief Complaint: Left lower chest pain and cough of nine months duration.

Present Illness: The patient was in excellent health until November, 1950, when he began to have left lower chest pain and occasional minimal hemoptysis. He was examined by his physician and told that there was nothing wrong with him. Because of continuing chest pain the patient saw another doctor in December, 1950, who gave him some pain pills and liver shots with no apparent benefit.

In February, 1951, the patient became febrile and his chest pain became more severe. His cough was productive of as much as a cupful of yellow sputum daily. He suffered from progressive weakness and fatigability. X-rays revealed fluid in the left chest and he was treated for pneumonia. In March, 1951, he entered a hospital and was told that he had virus pneumonia. he was treated with aureomycin and chloromycetin® for three weeks. The patient's temperature became normal but his cough and left chest pain continued.

In May, 1951, he saw another physician who told him that he could have tuberculosis and advised a bronchoscopic examination. This was performed and nothing abnormal was found. Bloody fluid was aspirated from the left chest at that time. Repeated thoracentesis revealed brown watery fluid and did not aid in making a diagnosis. A diagnosis of histoplasmosis was entertained but never established. Three weeks before his present admission the patient became short of breath. There has also been progressive anorexia, weight loss, weakness, and general malaise. On August 25, 1951, his physician advised him to enter the Ohio State University Hospital for evaluation and therapy.

Past History and Systemic Review—Noncontributory.

Physical Examination: Temperature 99°; pulse 120; respirations 20; blood pressure 118/90. A 40 year old colored male was seen lying in bed and who appeared chronically ill, toxic, and slightly disoriented. He was fairly well developed and fairly well nourished. The positive physical findings included an evidence of recent weight loss, dyspnea, cyanosis, decreased expansion and dullness of the left chest. There were moist rales in the right chest. The liver was palpable three finger breadths below the costal margin and the spleen was detectable.

Laboratory Data: Urinalysis, bromsulfalein test, red blood cell count, hemoglobin, phenolsulfonphthalein test, total protein, A/G ratio, Van den Bergh, chlorides, sodium, potassium, prothrombin, blood urea nitrogen, alkaline phosphatase, and cephalin flocculation were all normal. A posteroanterior roentgenogram of the chest showed complete obliteration of the left lung field by fluid, and displacement of the trachea and the esophagus to the left posteriorly and some thickening of the pleura in the left chest.

Hospital Course: Six hundred cubic centimeters of yellow-amber, viscid fluid were removed from the left chest. The fluid revealed no malignant cells. Venous pressure in the right arm was 200 mm. of water and the circulation time was, arm to tongue, 18 seconds and arm to lung, 10 seconds. On the third hospital day, while lying quietly in bed, the patient expired.

Autopsy Report: Massive bronchiogenic carcinoma of the left lung hilus with invasion of the mediastinum and direct extension into the lumen of the right auricle. There was atelectasis of the left lung. Metastases to the liver, right adrenal, and right kidney were demonstrated.

Comment: This patient had numerous examinations and was treated for pneumonia by several physicians over a period of nine months. His history is compatible with, but not diagnostic

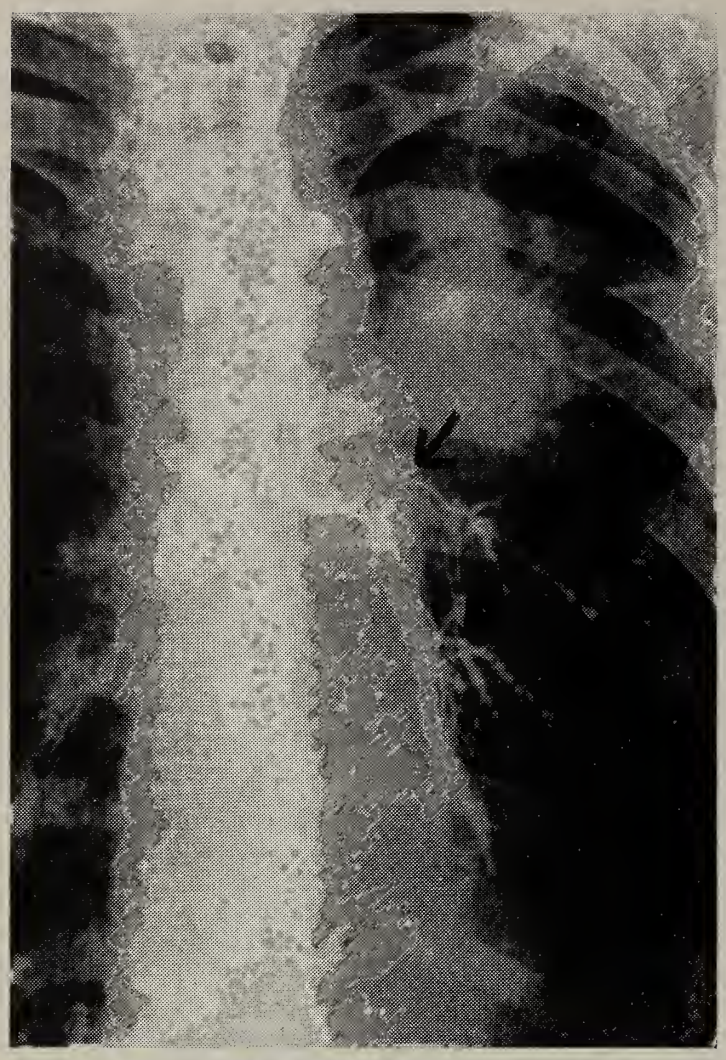


Fig. 1. Bronchogram showing occlusion of the left upper lobe bronchus. Note "pneumonia" distal to this occlusion.

of, pulmonary cancer. However, without a high index of suspicion, and without the benefit of exhaustive diagnostic aids the correct diagnosis was not established. This case illustrates the danger in making a diagnosis of virus pneumonia and the difficulty in determining the presence of bronchiogenic carcinoma.

Case 2. Admitted July 15, 1952.

Chief Complaint: Weight loss of 25 pounds in the last six months.

Present Illness: The patient stated that he has had asthma most of his life with a cough productive of white, frothy sputum. In the past six months he has lost 25 pounds and has had occasional minimal hemoptysis. In February, 1952, the patient developed a dull ache in the left upper chest which lasted three months. His physician told him that the ache was due to coughing and the patient was treated for asthma. X-rays were taken in the spring of 1952 and they showed a density in the left upper chest. Because of continuing weight loss and aching in the left chest, the patient was referred to the Ohio State University Hospital for studies.

Past History: No previous hospitalizations. Systemic review was otherwise physiological.

Physical Examination: Temperature 98.6°; pulse 76; respirations 18; blood pressure 122/84. A 47 year old, 109 pound, fairly well developed, rather poorly nourished American Indian appeared in no obvious distress. The positive physical findings included an evidence of recent weight loss, increased anteroposterior diameter of the chest, expiratory wheezing throughout both lung fields, and decreased breath sounds in the left upper chest.

Laboratory Data: Urinalysis, complete blood count, serology and examination of the sputum for tuberculosis were all negative. X-ray of the chest showed considerable emphysema with infiltration from the left hilum, extending up into the left upper lobe as a fairly dense involvement of the apical portion of the left upper lobe (Fig. 1). Bronchoscopy revealed no abnormalities and Papanicolaou slides of the bronchial aspirations revealed no malignant cells. The bronchogram showed bronchial occlusion of the left upper lobe (Fig. 1).

Hospital Course: After proper preoperative preparation a left thoracotomy was performed on July 17, 1952. The left upper lobe of the lung appeared necrotic and no definite tumor could be found. The surgeon could not determine the exact nature of the pathology. Frozen section revealed only necrosis and diffuse inflammation. However, it was the impression of the operator that this represented a malignancy and a left pneumonectomy with lymph node dissection was performed. Examination of the gross specimen by the pathologist failed to show a tumor and the lung showed only diffuse inflammation. However, final fixed microscopic sections revealed undifferentiated bronchiogenic carcinoma with marked acute inflammatory necrosis of the left lung. The patient had an uneventful postoperative course and was discharged as improved on July 25, 1952.

Comment: This case is of interest inasmuch as the history, the physical examination, and an

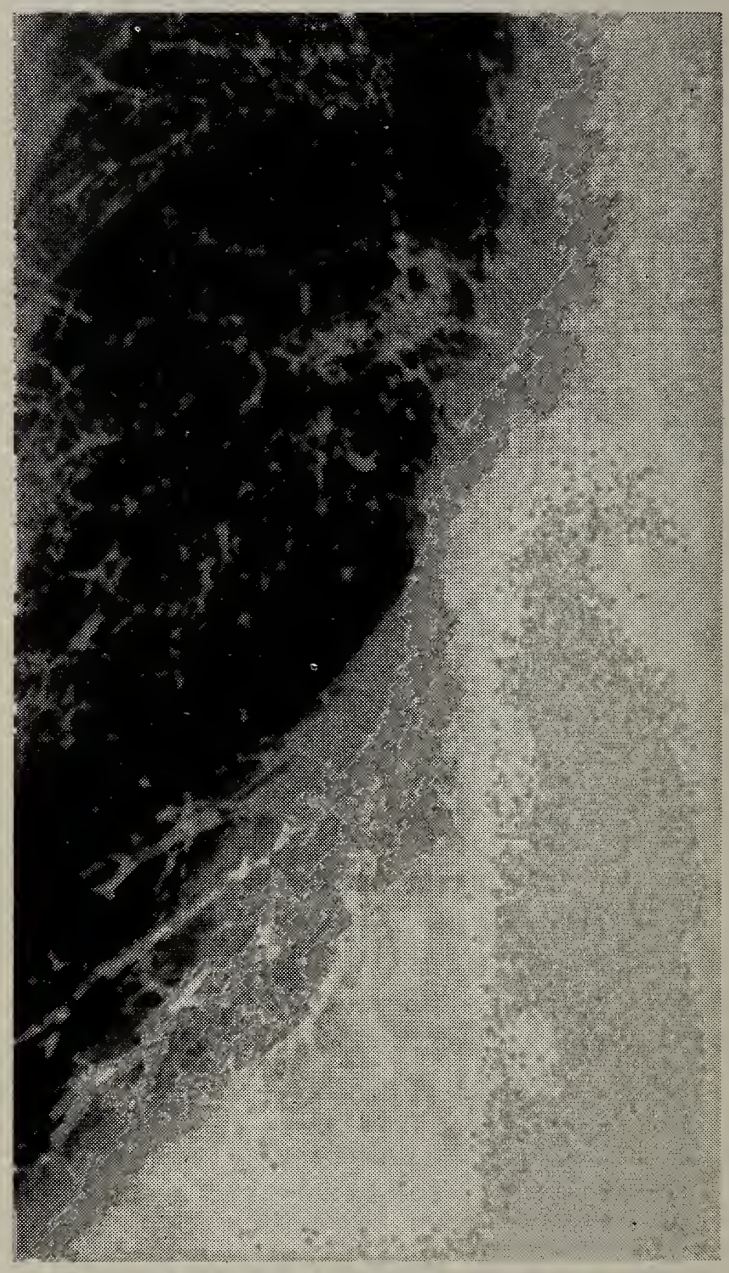


Fig. 2-A. Atelectasis of right lower lobe produced by a carcinoma of the bronchus.

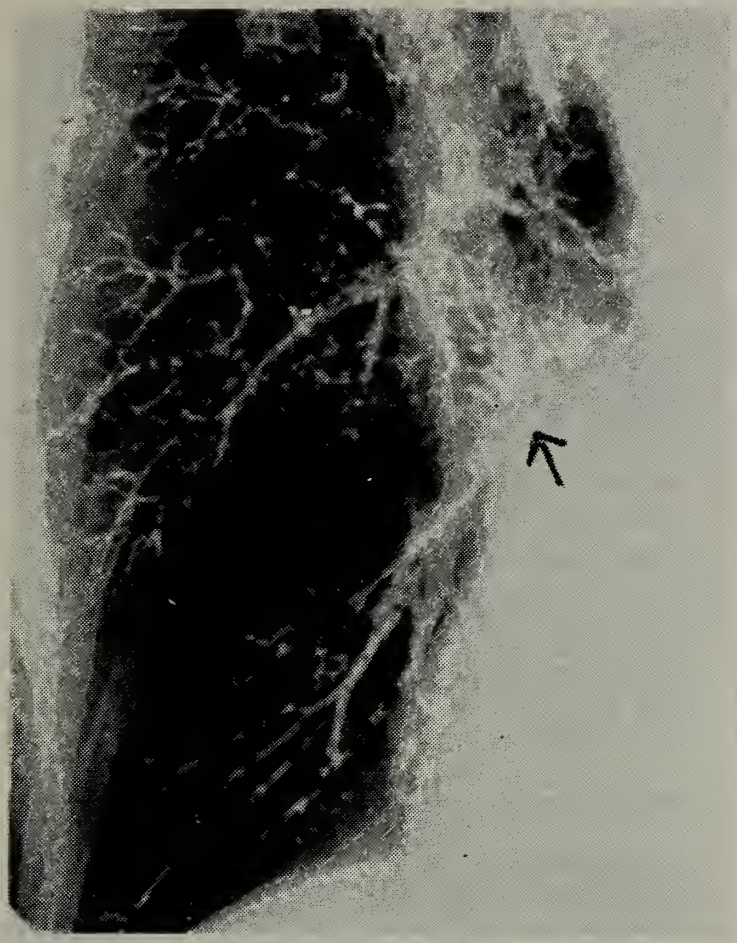


Fig. 2-B. The bronchogram illustrated the point of obstruction.

extensive diagnostic search gave no positive findings of bronchiogenic carcinoma. The x-ray and the bronchogram shows only a density in the left upper lobe and left upper lobe bronchial obstruction. Thus, the possibility of pulmonary malignancy could not be ruled out. This case also demonstrates that occasionally it is extremely difficult to diagnose the cancer grossly even when the surgeon has the lung exposed. In the presence of diffuse inflammatory necrosis the frozen section reports are often misleading and the decision rests entirely with the judgment and experience of the thoracic surgeon.

Case 3. Admitted August 6, 1952.

Chief Complaint: Progressive shortness of breath and weakness for 15 months duration.

Present Illness: This patient has had a chronic cough productive of thick white sputum for many years. The cough became more severe in the summer of 1951. The patient was hospitalized in August, 1951. He had x-rays of his chest and a bronchoscopy and nothing pathologic was found. The patient's condition remained the same.

In February, 1952, the patient had chills and fever and was treated with antibiotics for virus pneumonia. He lost twenty pounds in the next three months. In May, 1952, he was hospitalized complaining of weight loss, anorexia, hemoptysis, dyspnea, weakness, and some pain in the right chest. X-rays and examinations of the sputum for tuberculosis were negative. He was again told that he had a virus pneumonia.

In July, 1952, he entered the hospital and was told that he had a chronic bronchitis and was again treated with penicillin and streptomycin. The patient was admitted to the department of thoracic surgery at the Ohio State University Hospital on August 6, 1952, for diagnosis and therapy.

Past History: Noncontributory.

Physical Examination: Temperature 102.8°; pulse 88; respirations 36; blood pressure 110/70. This 64 year old, fairly well developed, fairly well nourished, white male was complaining of a chronic irritative cough. The positive physical findings were as follows: The base of the right chest showed increased tactile fremitus and decreased resonance and breath sounds.

Laboratory Data: The complete blood count, serology, and urinalysis were normal. X-ray of the chest showed an atelectasis of the right lower lobe of the lung and nodular infiltrates in the right hilum (Fig. 2-A). The bronchogram demonstrated a failure of visualization of the right lower lobe bronchus (Fig. 2-B).

Hospital Course: On August 8, 1952, a right thoracotomy was performed. An unresectable malignancy occluding the right lower lobe bronchus was found. Biopsy was taken and the right vagus nerve was cut to obtain relief from coughing. The patient was discharged to his home on August 16, 1952, as unimproved. The pathological diagnosis was moderately well differentiated squamous cell carcinoma.

Comment: Here is a patient who has had symptoms of pulmonary pathology for many years. He had progressive symptoms for over a year with repeated bouts of pneumonitis. A pulmonary malignancy was not considered until the bronchus had been completely occluded. This case demonstrates the fatality of procrastination in dealing with an elusive disease such as bronchiogenic carcinoma.

SUMMARY AND CONCLUSIONS

The more common causes of delayed resolution of pneumonitis and the diagnostic measures employed in making the differential diagnosis of unresolved pneumonia and bronchiogenic carcinoma are discussed.

Three case histories of bronchiogenic carcinoma are presented to emphasize the dangers and difficulties encountered in making the correct diagnosis.

The increasing incidence of pulmonary cancer presents a challenge to all physicians that can only be met by a high index of suspicion and the utilization of the available diagnostic techniques. Therefore, we must be aware that recurrent virus pneumonia and protracted lobar pneumonia are infrequent in adults without underlying lung pathology. We should suspect any patient suffering from pneumonia who does not respond to adequate antibiotic therapy within three weeks of having either a Friedlander pneumonia, lung abscess, tuberculosis, or bronchial obstruction. All efforts should be made to arrive at the correct diagnosis as early as possible and any patient with pulmonary pathology in whom bronchiogenic carcinoma cannot be excluded by other means is entitled to an exploratory thoracotomy.

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Practical Aspects of Burn Therapy*

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FAILURE to adhere to a rigid plan of management in the extensively burned patient, either through delay or omission of details, results in a chain of events leading to loss of life or at best, a prolonged, painful, and expensive convalescence with a high incidence of disabling deformities.

It is our purpose to describe a practical and relatively simple method of burn therapy which has proven safe and effective at the University Hospital during the past three years.

FIRST AID MANAGEMENT

First aid therapy includes all treatment given by emergency personnel or a physician in attendance prior to removal of the patient from the scene of disaster. As soon as feasible all clothing and constricting jewelry should be removed except those adherent to the burned surface. The patient is then covered with or wrapped in a clean sheet and the burned skin is not further disturbed. Contrary to popular belief, the application of oils, ointments or even butter do not relieve pain significantly nor aid in wound healing and frequently may be harmful since such materials must be removed at the time of initial dressing.

Although superficial burns are painful, deep second and third degree involvement is relatively painless, and little or no narcotics are required. As a matter of fact, heavy narcosis frequently complicates the treatment and clinical evaluation of the patient and may even contribute to shock. If morphine is required for associated injuries, it should be given intravenously since absorption by other routes is unpredictable and may lead to over-dosage. Restlessness is easily controlled by small doses of a short acting barbiturate.

One million units of aqueous penicillin should be given as soon as practical to insure saturation of the wound exudate and its incorporation in the burn crust.

Despite the patient's repeated request for water to drink, fluids by mouth should be given with extreme caution, since excessive oral fluids may lead to persistent nausea and vomiting. In addition, Moyer[10, 11] has called attention to the danger of further diluting the already depleted body electrolytes and in turn the possibility of water intoxication. Since large amounts of sodium chloride and bicarbonate are lost into the burned areas these electrolytes should be added to the oral fluids. This "Salt-Soda" solution is easily prepared by the addition of one level tablespoon of table salt and one teaspoon of baking soda to a quart of iced water. The amount of this to be consumed by the patient is limited to one or two quarts during the first day and when taken as sips serves to quench the thirst.

Hospitalization should be accomplished as soon as transportation becomes available. For purposes of clarity, further therapy will be considered as being of an emergency but more definitive nature.

EMERGENCY MANAGEMENT

The primary evaluation for the extent and degree of the burn, the patient's general condition and the presence of associated injuries must be done quickly since impending or actual burn shock should be treated as soon as possible. The initial venipuncture is accomplished with a large caliber (Number 15) needle, the tourniquet is removed, a sample of venous blood is collected for immediate crossmatching and base line hemoglobin or hematocrit determinations and the most readily available parenteral fluid (e. g., pooled plasma, normal saline or 5 per cent glucose in water) is started intravenously. If the burn is extensive or the hemoconcentration is marked, plasma or a plasma expander (e. g., polyvinylpyrrolidone, dextran or gelatin) is given at once. In anticipation of a large fluid requirement, one or more large superficial veins are isolated and a short length of polyethylene tubing inserted as a cannula.

The hourly urine output is the simplest and most accurate guide to subsequent therapy of burn shock.[3] Accordingly an indwelling catheter is inserted in the urinary bladder, the bladder is emptied by manual compression and the catheter is attached to a short length of rubber tubing.

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The exact time is noted on a simple bar graph and the subsequent urine output is charted in cubic centimeters per hour. The initial urine and several of the hourly specimens are examined for evidence of primary kidney disease and the presence of red blood cells or hemoglobin breakdown products.

As noted previously, one million units of aqueous penicillin is preferred as the initial antibiotic. An additional 300,000 units of a depository penicillin given simultaneously and repeated daily thereafter will insure a constant blood level. Tetanus antitoxin or toxoid are given with the usual precautions and dosage.

After shock treatment is well under way attention is turned to a more accurate evaluation of the extent of the burn since subsequent management of burn shock is based on the percentage of body surface involved. If shock is well in hand, one should proceed with the initial dressing and these observations are made at that time. On the other hand, if the clinical signs of burn shock are still present and the urine output is less than 25 cc's per hour, local treatment must be postponed. In these instances, an earlier estimate of the burn surface may prove helpful, but must be done quickly and under relatively aseptic conditions.

The tendency to overestimate the extent of the burn in adults and to underestimate those in children must be remembered. A previously prepared anatomical outline showing portions of the body surface marked off in percentage (Fig. 1) enables the clinician to easily sketch in the burned areas and arrive rapidly at an accurate estimate of the total burn.[4] This information together with the estimated or actual body weight permits an accurate calculation of the fluid and electrolyte requirements for the first two days of treatment. A slight modification of the formula suggested by Evans[9] has proved most useful.

FLUID REQUIREMENTS

The fluid requirements during the first 24 hours are calculated as follows:

½ Body wt. X % burn = cc's. colloid
½ Body wt. X % burn = cc's. saline

One half the amount of colloid is given as plasma or a plasma expander and the remainder as whole blood.

If oral fluids are tolerated, one or two liters of the "Salt-Soda" mixture is given by mouth and the remainder of the saline requirements are supplied intravenously as 5 per cent glucose in normal saline. In general, the maximum colloid and salt intake during the first day is limited to 8 liters no matter how extensive the burn. An additional 2000 cc's. of 5 per cent glucose in water is given to replace the normal daily fluid loss. On the 2nd day, the intake of colloid and salt is reduced by one-half and subsequent fluid therapy is regulated by the patient's state of hydration.

One-half of the calculated first day requirement is given during the initial 6 to 8 hours and if burn shock is severe, the complete 24 hour esti-

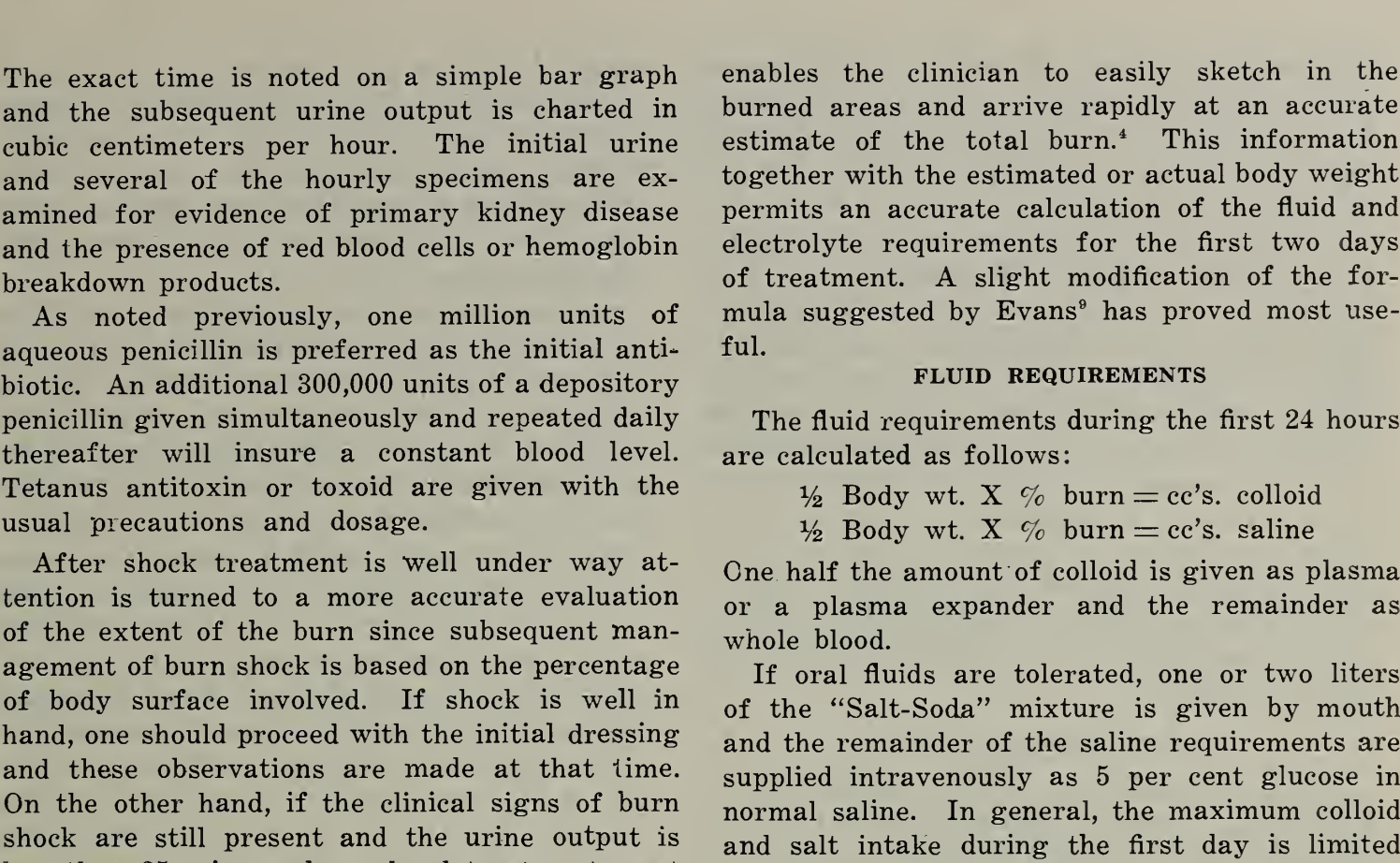


Fig. 1.—A previously prepared anatomical outline showing portions of the body surface marked off in percentage enables the clinician to easily sketch in the burned areas and arrive rapidly at an accurate estimate of the total burn. (After Cope)

mate may be needed. In these instances, fluid planned for the following day is given during the final hours of the first day; however, the estimated 48 hour requirement should not be exceeded.

Although the fluid requirements calculated by the foregoing formula are reliable, it is best regarded as a working estimate only and the actual fluid intake is regulated by following the hourly urine output. For this reason, constant bladder drainage by means of an indwelling catheter is routine in all severely burned patients and fluid therapy is regulated to maintain a urine output of at least 25 cc's. but not over 100 cc's. per hour. An hourly urine flow below 25 cc's. usually indicates an inadequate fluid intake but may denote a more serious situation, i. e., the development of a renal shutdown and impending death.

WATER TOLERANCE TEST

In these instances, the "Water Tolerance Test" proposed by Cope[3] is extremely helpful in differentiating the adequacy of treatment from the inadequacy of the kidneys. This consists of administering one liter of fluid by vein within one-half hour (5 per cent glucose in water or normal saline) and carefully measuring the urine flow. An increased urine output indicates a satisfactory kidney function and clearly demonstrates that the demands for fluid have not been met. On the other hand, a failure to note an increased flow of urine suggests renal damage, and under such circumstances the calculated requirements are closely maintained so as to avoid overhydration. The prognosis in such cases is guarded.

If the urine output persistently exceeds 150 cc's. per hour during the first two days of therapy, the fluid intake should be drastically reduced. Excessive urine output from the third to the seventh day indicates mobilization of fluid from the burned area and failure to recognize this "spontaneous diuresis" together with a continued high fluid intake usually results in pulmonary edema.

Short-term parenteral cortisone therapy may be of value in supplementing corticosteroid hormones presumably inadequate in severely burned patients.[5] In these rare instances, 75 mgs. of cortisone is given every six hours for a 48 hour period; 200 mgs. daily for an additional two days and 100 mgs. on the fifth day completes the program. Transient cortico-adrenal insufficiency is avoided by substituting ACTH in gradually decreasing doses for a four day period. It should be emphasized that further than this, ACTH is of no benefit to the burned patient.

LOCAL TREATMENT

Local treatment of the burn wound is not begun until initial shock is controlled. In most instances, anesthesia is unnecessary and should be avoided since a cooperative patient is desirable and its effect on burn shock is unpredictable. The same sterile techniques are used in the primary dressing as are applied to the care of all open wounds and is best considered an operating room procedure.

Having removed adherent clothing and gross dirt, the burn wound and adjacent skin is gently cleansed with pHisoderm® or a bland soap applied with soft cotton sponges and irrigated with sterile normal saline. Skin blebs are opened, the raised epithelium removed, and a second flushing with saline completes the initial debridement.

The wound is then covered with a single layer of relatively dry fine mesh petrolatum gauze or a fine mesh nylon cloth and an absorptive dressing of sterile gauze flats (4x4's) and abdominal pads or mechanic's waste is held in place with several turns of a five yard head roll. An elastic compression bandage applied evenly but with only gentle pressure completes the burn dressing. Burned extremities are immobilized in a position of function with light weight plaster splints and elevated on pillows. The one piece dry burn dressing advocated by Evans[8] provides a simple, effective and rapid method of covering extensive burned areas and when generally available should be used to advantage.

Although the "closed" occlusive dressing is the treatment of choice, the "open" or exposure method of burn therapy is satisfactory for superficial burns combined to one side of the body.[12, 13, 14] The latter is especially applicable for burns of the face or perineum and might prove to be the only feasible method if faced with a large number of burn casualties. The initial care remains the same, and after debridement, the patient is placed in bed on clean sheets in the position best ensuring rest, elevation, maximum exposure and, in turn, drying of the burned surface.

Drying of the burn exudate results in a hard, adherent and protective crust in 48 to 72 hours. Superficial burns heal rapidly and spontaneous desquamation of the crust is complete by the end of the second week. Although the crust over full-thickness burns tends to remain fairly adherent, it cracks frequently and thereby invites infection. Suppuration is avoided by daily inspection of the burn surface at which time curled up edges of the cracked crust are trimmed and the areas covered with small saline dressings.

DEFINITIVE THERAPY

Subsequent management of the severely burned patient requires detailed attention towards the maintenance of nutrition, the correction or prevention of anemia and the control of infection. Oral feedings are begun on the first post-burn day and increased with tolerance. At least 1

gram of protein and 20 calories should be supplied for each pound of body weight, with a minimum of 150 grams of protein and 3,000 total calories for the average patient. Between meal supplementary feedings are frequently needed to meet these requirements.

If anorexia is severe, a small caliber polyethylene tube is introduced into the stomach and a nutritive feeding mixture is administered intermittently or by continuous gravity drip. It is well to start such feedings with homogenized milk, supplementing later with protolysate® and dexin.®[15] The volume is gradually diminished as oral intake improves and is discontinued when the patient is taking sufficient calories by mouth. Dietary vitamin C is supplemented with 0.5 grams of ascorbic acid twice daily.

The prevention of anemia by multiple small transfusions of fresh whole blood[7] and the control of infection by continued vigilance and judicious antibiotics permits excision of full thickness burn sloughs within two or three weeks and in turn early skin grafting.

SKIN GRAFTING

Frequently changed moist saline compresses are recommended for three days prior to the application of skin grafts. A single layer of fine mesh gauze adjacent to the granulating surface serves to minimize pain and bleeding at the time of subsequent dressings. This is followed with several layers of gauze flats moistened with sterile normal saline and a few turns of moist five yard gauze head roll. Rubber and plastic covering are omitted for fear of maceration and the wet dressing is completed with several thicknesses of a dry head roll. The affected part is elevated if possible and the entire dressing is changed every four hours, day and night, for three days prior to grafting.

In general, the use of pinch grafts should be condemned. Interval transfer of large sections of split thickness skin, sutured in place with interrupted fine silk, is the preferred method of covering the burned surface.[1, 11] Flexion surfaces of the arms and legs should be grafted first to minimize contracture and permit early mobilization. Light compression dressings over grafted sites are left in place for 10 to 14 days; however, if infection is a problem, the areas are inspected as early as the third post-graft day and saline compresses are reapplied.

Donor sites are dressed with fine mesh nylon cloth, reinforced with several layers of standard mesh gauze, fixed in place with occlusive absorptive dressings and left undisturbed for 14 days.

The application of split thickness skin from volunteer donors may be of value as a temporary dressing following surgical debridement of an extensive full-thickness burn. During the first few weeks the homografts behave not unlike a corresponding autograft, however desquamation begins by the 21st day and is complete by the eighth week, giving an average survival time of about four weeks. Excision of small sections of homologus skin and replacement with the patient's own skin is continued at weekly intervals until all areas of full-thickness loss are covered. It should be noted that during this period of temporary coverage, areas thought to be full-thickness loss may heal by spontaneous epithelization and require no further grafting. ACTH and cortisone do not prolong the survival time of homologous skin grafts.[6]

SUMMARY

A practical, relatively simple and effective method of burn therapy has been presented with emphasis on the following: First, the initial shock must be anticipated and steps taken immediately to maintain an adequate blood volume. Every effort must be made to minimize contamination and discourage bacterial growth, since infection is the second most important factor influencing the outcome of burn therapy. And finally, the same close attention to the caloric and protein needs of the burned patient and the prevention of burn anemia by the liberal use of whole blood transfusions permits surgical debridement within two or three weeks and early grafting. And it is only through prompt coverage of the burn surface and in turn early mobilization that one can realize a shortened rehabilitation with minimal contractures.

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The Use of Split-Thickness Skin Grafts In a Bilateral Ischiorectal Abscess

FRANK J. RACK, M.D.

TWO problems which are frequently of concern in the management of an ischiorectal abscess are slow healing and fistula formation. In many instances, especially with large abscesses, varying amounts of perianal skin must be sacrified to assure adequate drainage over a prolonged period and proper granulation from the bottom of the cavity. In such cases slow healing is the rule. Morbidity is frequently of several months' duration and throughout this period the patient is burdened with a perineal dressing.

The formation of a fistula in ano following drainage of an ischiorectal abscess is frequent. It can be avoided, however, if the original focus of infection in the anal crypt, duct or gland is eliminated at the time of drainage of the abscess. Careful search for the primary focus of infection should always be undertaken at the time of drainage.

It is the purpose of this report to describe a case presenting a large bilateral ischiorectal abscess without subsequent fistula formation and early healing with the aid of split thickness skin grafts.

CASE REPORT

The patient, a 48 year old obese colored woman, was admitted to Cleveland City Hospital with the complaint of rectal pain of two weeks' duration. Seven days before admission some drainage developed from the buttocks and her family physician made an incision over the draining area. The pain continued, however, and chills and fever developed.

On admission to the hospital examination revealed extensive areas of skin necrosis over both lateral perianal areas with a centrally located draining sinus in each area. A diagnosis of bilateral ischiorectal abscess, incompletely drained, was made.

Under general anesthesia both ischial rectal fossae were opened and it was found that the abscesses communicated posteriorly across the midline. Anoscopic examination revealed a posterior midline fissure with a sentinel pile and considerable cryptitis in this area. This portion of the anorectal canal was excised. Following operation, the patient did well, but the perianal areas presented large skin defects bilaterally (Figure 1).

Six weeks after the original operation, split-thickness skin grafts were taken from the left thigh and sutured in place over the granulting areas. On the ninth day the sutures were removed from the grafted areas. Despite bowel movement five days after the grafts had been applied approximately 90 per cent of the grafted skin had taken. The patient was discharged asymptomatic 26 days after operation, the buttocks well healed (Figure 2).

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DISCUSSION

The proper management of ischiorectal abscess requires early drainage. Infection in a closed space as the ischiorectal fossa is dangerous. Rupture into the peritoneal cavity, bladder or opposite ischiorectal fossa is a constant threat until ex-

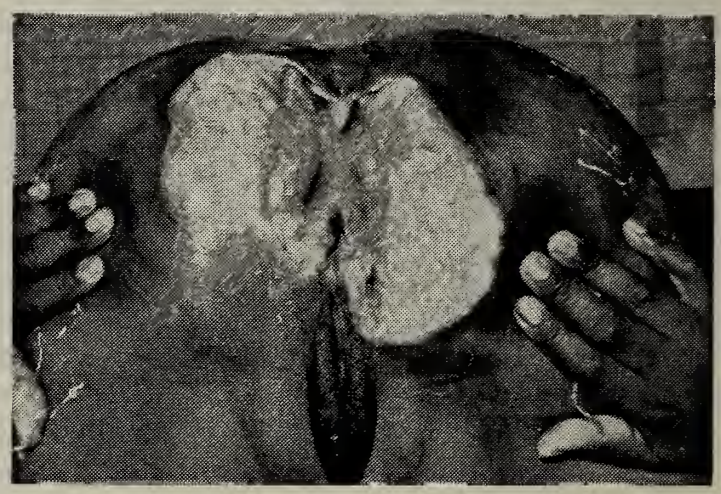


Figure 1. Photograph of the perianal region taken after incision and drainage of bilateral ischiorectal abscesses and just prior to the application of skin grafts. Much of the perianal skin is absent as the result of pressure necrosis which resulted from delay in draining the original process.



Figure 2. Photograph of the perianal region taken after the application of skin grafts to the defects over the ischiorectal fossae. Over most of the areas the grafted skin has taken.

ternal drainage is instituted. In this case prolonged unrelieved pressure on the skin over the ischiorectal fossa caused extensive necrosis of the skin. Following adequate drainage a large open wound resulted which would have required a protracted healing period. One solution to such a problem is the employment of skin grafts.

Experience with other cases such as hydradenitis suppurativa and severe pruritus ani which required grafts to the perianal areas leads one to believe that the fear of graft slough because of infection in this particular area is not well founded. Skin defects here can be adequately treated by split-thickness grafts. A most important factor for obtaining adequate takes is complete immobilization of the grafts. This can be done by employing stents and sutures strategically placed throughout the graft. Bowel movements should be inhibited for several days after surgery by employing suitable quantities of paregoric and complete bed rest.

SUMMARY

A case is reported in which a large bilateral ischiorectal abscess was successfully treated without fistula formation and without prolonged morbidity by utilizing two maneuvers: (1) excision of posterior cryptitis and fissure at the time of incision and drainage of the abscess, (2) early employment of split-thickness skin grafts to the areas of skin defect which resulted following drainage.

Aldrin Poisoning

Every company making insecticides endeavors to check toxicity of its product before placing it on the market. The effect on insects, on animals, and on the workers producing the drug is studied carefully. The literature is carefully perused for incidents of accidental poisonings.

Many workers in pesticide establishments are potentially exposed during manufacturing of these toxicants, yet if the formulators' manual and adequate precautions are adhered to, no deleterious effects should be encountered. When, the recommended directions have been ignored, the continued use will be accompanied by instances of human poisonings. Little is known otherwise of the toxity in man and no known method of testing the toxcity has been found.

That aldrin® may be deposited in fatty tissue has been considered. Aldrin® is the coined name of a new insect toxicant having the chemical formula C_{12} H_8 Cl_6 and the structural formula of hexachlorohexahydrodimethanonapthalene. It is an alkali stable compound, often referred to as Compound 118. Aldrin® is never applied to cotton within fifteen days of handpicking and there should be no danger if the insecticide is sprayed in its minute dilutions on food.—Eli Nelson, M.D., Denver; *Rocky Mountain Med J.* 50:483, June, 1953.

KEEPING UP WITH MEDICINE

• THE MALINGERER usually has the same complaints as the psychosomatic patient but in addition the history will give an immediate clue to the emotional drive which produced his complaints and it will be obviously a purposeful one.

* * *

• FUNCTIONAL disturbances of psychosomatic origin are said to be more common in the eye than in any other organ.

* * *

• How he carries himself may be the key to many of an arthritic's host of troubles, for sound health is more apt to be found in a well poised body.

* * *

• OBSTRUCTION, besides preparing the ground for infection, has deleterious effects on all parts of the urinary tract above the point of obstruction.

* * *

• URINARY CALCULI are the resultant of any or all of a number of factors, among the most important of which are stasis, infection, vitamin deficiency, hyperparathyroidism, and cystinuria.

* * *

• MALNUTRITION includes all inadequacies and aberrations of diet, as well as defects in absorption and utilization of food which lead to clinical manifestations.

* * *

• EVEN now, most individuals at 65 have a life expectancy to justify making plans ahead for 12.4 years for white males, and 14.4 years for white females (1948 figures).

* * *

• LIFE EXPECTANCY in 1850 at age 70 was a little longer than it was in 1946.

* * *

• THE WHOLE area of food acceptance represents an almost totally unexplored field of investigation and one of the most important health problems of the public. Nutrition education, which is the keystone in the foundation of health, is almost useless without this knowledge.

* * *

• OCCURRENCE of obesity in the lower income groups relates in a large part to the character of the diet which is likely to be composed of carbohydrates with a low price tag, but actually more expensive in terms of health and nutrition values.

* * *

• IT HAS been the undermining of the dignity of Man's human heritage and functioning—the constant pull to level him down to the level of animal behavior, that has been the real basis of opposition to Freud's system of thought.—J. F.

Brain Wave Patterns and "Crystallized Experiences"

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IN 1929 Hans Berger first described electrical rhythms arising from the cerebral cortex. The particular form of cerebral electrical activity which now bears his name, ("Berger Rhythm"), and is known as well as the alpha activity, is closely related to the rhythms which he originally observed. Many investigations have been undertaken to learn more of the nature of the alpha rhythm. Studies have been made of the appearance of this activity in EEG (electroencephalograph) tracings, its incidence in the various regions of the cortex, its origin and its relationships to consciousness and to mental activity.

Alpha activity is usually described as consisting of 8½ to 12-per-second-waves occurring in the parieto-occipital areas of the cortex especially, and in rather regular recurring runs. Recent studies of adults have shown that it is more easily recorded over association areas of the cerebral cortex (or elaborative cortex, as it has been termed), than from projection areas of the cortex (either sensory or motor). Thus, alpha activity is common over the posterior portion of the temporal lobe, the entire parietal lobe, and the anterior part of the occipital lobe. However, it can also be found over the anterior frontal cortex and to a lesser degree over the sensory projection cortex and the precentral motor cortex. In young children, the alpha activity often arises from a wider area than it does in adults.

The alpha activity has been considered by some workers to be intrinsic in the cortex, while others have held that it is "driven" by subcortical structures. Studies of isolated cortex have shown activity which appears to be of this alpha nature so that it does seem to be a cortical activity per se; although it is possible that it may be driven by subcortical rhythms of a similar frequency, as well.

Alpha activity is blocked when an attention factor is operative. Since attention is commonly paid to sensory signals, it was formerly thought that the sensory projection cortex blotted out alpha activity in the adjoining association cortex, by a simple diffusion of "impulses," but it is now believed that this is too simple a conception. Furthermore, alpha activity is blocked when attention is paid to mental images (notably visual ones) as in preoccupation with phantasies.

Recently, it has been postulated that there are two systems (at least) of neurones in cerebral patternings. One of these is the well known sensory-adjustor-motor "pathway" which enters the cortex through sensory projection areas and leaves through motor projection areas. The other system has to do with excitability and with consciousness, and covers behavior ranging from coma to convulsions, and including, in the central portions of that range, the phenomena of sleep and wakeful alertness.

It has been postulated that the alpha activity is one of the functions of this second system of neurones. In other words, the alpha waves are said to be related to the regulation of a level of excitability. Thus, alpha activity may be thought of as representing one aspect of "the activity of the regulating system itself" (Davis, 1950), rather than that which is regulated. Finally, it may be supposed that the high incidence of the alpha or regulating activity in a brain wave record indicates that the regulating mechanism was operating alone and that there was a concomitant lack of cerebral activity in terms of sensory attention, thinking and planning.

There has been some investigation of the matter of the mental make-up of those persons who have a large amount of alpha activity in their EEG records. It has been stated that schizoid personalities have a high alpha incidence (Lamere, 1936), and that "very passive" individuals with receptive trends have "high alpha" EEG's (Saul, Davis and Davis, 1937).

It has also been postulated that persistent alpha rhythms may be more common in individuals who draw upon auditory or somesthetic memories rather than upon visual ones in their thinking and phantasy structuring, (Golla, Hutton and Walker, 1943).

MATERIALS AND METHODS

This study concerns 25 white males who were patients in a Veterans Hospital. These men were selected for this study on the basis of their waking EEG records alone. During the reading of several hundred EEG tracings, these 25 rec-

From the Chillicothe Veterans Administration Hospital, Chillicothe, Ohio. The opinions expressed herein are those of the authors and do not necessarily represent either the viewpoints or policies of the Veterans Administration.
Submitted March 6, 1953.

ords stood out from all of the others because of the high incidence of alpha activity in the tracings.

The majority of these records were so-called "monopolar" tracings with recordings from occipital, parietal, temporal, and frontal leads. All of the records were interpreted as normal in terms of the absence of the slowing that is characteristic of cortical deterioration, and of seizure discharges indicative of a convulsive disorder.

As each case came along, the clinical folder was reviewed, social service reports were studied, and a history was taken from the patient himself. Advantage was taken of other forms of clinical and laboratory investigation. The diagnostic procedure included examination by the Clinical Psychology Service in most instances. Each of these patients was given one or more psychiatric interviews. An attempt was made to obtain all of the evaluations of a single patient as near the same time as was possible.

The great majority of these patients were nonpsychotic at the time of this evaluation. In fact, a longitudinal study of the patients showed that any psychotic reactions which had occurred were almost always episodic in character. Most of these patients carried a diagnosis of inadequate personality, schizoid personality, or immaturity reaction.

CLINICAL DATA

These 25 men were characterized by their conformity to authority, which in turn seemed to represent an inability to express aggression. Clinically, they tended to be quiet, passive individuals, and it was only in their psychotic episodes that they showed much projection of their inadequacies outward.

This type of patient usually entered the hospital with vague complaints of nervousness which he was commonly unable to express as definite symptoms. He usually accepted hospitalization without protest. He may have entered voluntarily, and as a matter of fact often looked upon the hospital as a refuge. Although he was not actually psychotic he accepted without protest the restrictions placed on the psychotic individual, and seldom objected to being "warded" with frankly psychotic people. On the ward this type of patient was aloof without being asocial; he remained to himself unless a more aggressive patient took the initiative and contacted him.

At the time of these studies, the social inadequacy with its dearth of available ideas and an inability to verbalize symptoms often led observers to believe that this variety of patient had an intelligence quotient much lower than it actually was. Actually there is nothing to indicate that this type of person has any definite intelligence level and the evidence is entirely against the existence of anything approaching mental deficiency.

The "typical" patient from this series complained of being very uncomfortable in the presence of other people and he described a paralysis of thought and an inability to function either mentally or physically in the presence of others. The unmarried patient became "asocial" and encysted, and he often utilized alcohol to ease his discomforts.

When he was able to break down his complaint of "nervousness" it became apparent he was not mimicking and that his complaints were real and disabling. He appeared "neutral" in attempting to place blame for his condition; he seemed to realize vaguely that his symptoms were due to some lack of equipment within himself. He seldom developed ideas of reference, semi-delusional thinking, or delusions unless he became frankly psychotic.

Studies by the Clinical Psychology Service near the time of the EEG studies made mention of such findings as the following: "rigidity," "basically passive-dependent," "tries to avoid aggression at all costs," "strong need to conform," "little originality of thinking," "afraid to contact the environment," "barrenness of associated processes," "a rigidity of approach which enables him to avoid new and threatening situations," "He avoids situations in which he is expected to perform in the adult role," and "He is unsure of his role as a man."

FAMILY HISTORY DATA

When an attempt was made to find the major causative factor in the social deficiency of these 25 male patients, such an area appeared in their relationships with their fathers. Case history after case history shows that the early lives of these patients placed them in unsatisfactory relationships with their fathers so that identification with the male model was impaired or absent.

Of the 25 patients, two were *only* children, four were *only* sons, nine were the oldest sons of their families, and three were the babies of their families. Thus, seven only of the 25 men were in a "neutral position" in their early family experiences.

It is commonly recognized that the boy who is an only child and also the only son in the family is particularly in need of good father relationship since he lacks brothers with whom he can identify. Of the two men who were *only* children, one's father was a chronic invalid, and the father of the other was a soft, passive character. The four men who were *only* sons all had poor father relationships. One father was openly cruel to the mother, the second was a chronic alcoholic, the third was described as "cold and distant," and the fourth died when his son was only three years of age.

The oldest son of the family is often con-

fronted with excessive demands that he be like the father. In other families there is strong competition between the father and mother for the interest and affections of the oldest son. The youngest son, on the other hand, is often pampered by the entire family. Nine of these men were the oldest sons in their families, and three were the youngest children in their homes.

Of the remaining seven patients whose family position was less vulnerable, four had cruel critical, or rejecting fathers, while the remaining three had noticeably passive fathers and active, domineering mothers.

Eleven of these men had never married although the average age for the group was about 33 years; and eight of the 11 who never married were 30 or more years of age.

CONTROLS

As controls we have studied 15 cases of men of similar ages who appeared "passive" clinically but who had histories which showed adequate early identifications with their fathers (or father substitutes). The histories of these 15 men also showed that they later developed needs to reject their father identifications and that they were caught up in conflicts between accepting and rejecting their fathers and the masculine role in life. None of these 15 men showed a high incidence of alpha activity in their electroencephalograms.

A typical case was that of a 26 year old man who was the second of three sons. His father was living, but his mother died when the patient was ten years of age. Clinically, he was quiet, shy, evasive, passive, cooperative, and attempted to please everyone who took care of him. The father of this patient had been demanding and had forced all of his sons to work hard. The patient had worked for his father although several persons had repeatedly pointed out that the father was taking financial advantage of him. On several occasions the patient had left the father's employment but he had always returned. His admission to the hospital followed an attempt at suicide. The EEG of this man showed only a low average amount of alpha activity.

DISCUSSION

It is our belief that because all 25 of these men had made poor identifications with their fathers during their early formative years, they consequently had never built up adequate neural machinery for acting out a masculine role in adult life. This inadequacy is especially noticeable in their inability to express aggression at a conscious level. Hence, these patients are characteristically "passive" and dependent.

It is our belief that the defective Ego aspect of their personalities which had resulted from inadequate father identifications, was manifested by inactivity in the higher cortical levels of sensory association, thought elaboration and motor synthesis. We would postulate further that the absence of cortical activity of the type associated with thought and planning in these areas is evidence of an absence of "crystallized experience" in the brain, and further that this experience is the type which arises from successful identifications by the male child with his father.

The high alpha incidence in the EEG's of these patients may well indicate an absence of the cortical activity usually found in normal adult males. The alpha activity itself is considered to be nothing more than a remaining regulating or scanning mechanism which may roughly be equated with an "idling brain" that is not actively dealing with life's problems.

It should be emphasized that high alpha incidence cannot be correlated directly with clinical "passivity." As pointed out above, non-aggressive and dependent males may be men who have masculine identifications but who reject them, or they may be men with stronger, clashing feminine identifications. This paper does not deal with such individuals, but with individuals who have never structuralized, and hence lack masculine identifications in the personality makeup, and from our hypothesis, in their actual brain patterning.

HYPOTHESIS

This preliminary study is presented with the theory that the lack of capacity of the adult male to express masculinity may be based upon a dearth of "crystallized experiences" which should have been structuralized in his brain during childhood. This structuralization did not take place because of a failure to incorporate the thinking and acting of masculine models. This lack of capacity appears as a relative absence of the brain wave patterns which are characteristic of cerebration. These neural activity patterns are replaced by alpha activity which in turn is considered to be a regulating mechanism in the brain, rather than a content pattern.

As an hypothesis, these findings may be used to support a truly psychosomatic approach to mental phenomenon.

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Curb Service for Diagnosis
The Mobile Laboratory

IRWIN C. ALBERT, M.D.

WHEN I returned from military service in 1945 and started the practice of medicine, one of the greatest problems was getting a patient into the hospital. How many physicians returning to civilian life in this year of 1953 are seeking ways of minimizing the same difficulty! The shortage of hospital beds, general throughout the country, was—and is—a problem at least annoying, and in some instances, downright serious for profession and patient alike.

So, in 1946, we started in Cincinnati an empirical experiment directed toward solving that problem in some measure.

Our results, over the more than half-decade, convince us that we have an instrument by which use of valuable bed space often may be avoided (in some cases, we have demonstrated, better avoided than not!). This to the benefit of more efficient and satisfactory practice of medicine; prompter treatment, greater comfort and sometimes greater safety for the patient; relief of the hospitals' loaded waiting lists, and savings for such prepayment hospitalization plans as recognize it.

Briefly, the core of our Hospital-Facilities-at-Home Service is a truck fitted with portable x-ray apparatus, developing equipment, an electrocardiograph, a basal metabolism testing unit and a microscope. Emergency blood counts may be done at the patient's home.

Intravenous injections of saline and glucose and transfusions are included in the service, but no other treatment: diagnostic procedures are emphasized.

The Service has gained the co-operation of most of the local doctors and the praise of many patients. In the frequent instances of its enabling a patient to remain at home there is the obvious advantage not only of releasing hospital bed space, but of relieving either the patient or his insurance company of the per diem room costs of hospital care. Dr. Anthony J. J. Rourke, American Hospital Association, has pointed out (in *Hospital Management* for May, 1952) that ". . . I am confident that prepayment plans will have to more rapidly help solve the problems of covering diagnostic procedures on an outpatient basis . . ."

Hospital-Facilities-at-Home Service is presented as such a means for effectively increasing in-patient accommodations by effectively and economically maintaining many potential hospital cases as out-patients.

Submitted April 16, 1953.

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● Dr. Albert, Cincinnati, is a member of the senior active staff, Jewish Hospital; assistant in medicine, University of Cincinnati College of Medicine.

EQUIPMENT AND PERSONNEL

Truck: A 1 ton panel truck houses our laboratory on wheels. Floor space is 4 by 6 feet, and floor to ceiling height, 6 feet. In order to maintain a fairly warm temperature, during the winter, an electric bathroom heater is kept on in the truck during the night. This is powered by wires strung from the garage. An automobile heater is kept on all day. This causes a constant drainage on the battery; the battery, therefore, is attached to a trickle charger overnight. The temperature control is important for stability of the x-ray developing solutions. In hot summer weather ice is added to the developing tank if the solutions' temperature reaches 80 degrees.

The van of the truck was made light-tight for dark-room use. Compartmented shelving for the various pieces of equipment were built in and the apparatus is kept in place with canvas straps. We use a Meyers roentgenographic unit but any standard portable machine can be used as long as it is light enough for one man to carry into a home and upstairs. The only sizes of cassettes used are 14 by 17 and 10 by 12 inches.

Developing Tanks: The tank unit is made of stainless steel and is specially designed to prevent splashing from one compartment to another. This was accomplished by making the tank deep enough for the top of the solution to be a foot below the top of the tank. A ridge to support the film holders is built in at the 5 gallon mark in both the developing and fixing compartments. The center (water) compartment is of 15 gallon capacity at a level one foot from the top. A stainless steel top fits snugly over the tank.

The tank is filled by running a rubber hose from an outside spout. Washing of the films in the stationary water has proved just as satisfactory as the standard procedure of using

running water. However, a longer wash period is required—we allow the films to "soak" for one-half hour before hanging them up to dry. The water is changed every 2 to 3 days to keep it clean.

Electrocardiograph: A Sanborn direct writer is used.

Work Table: There is a shelf 36 inches high, for loading and unloading the cassettes.

Central Laboratory: (This is mentioned here because, paradoxically, it originated as something of a stationary auxiliary for the mobile unit. When our service started, the laboratory work was limited to emergency blood chemical analyses and this necessitated use of a standard laboratory. We now have a complete clinical laboratory to which the specimens are brought and where we care for ambulatory patients. Our big "auxiliary" laboratory, it must be pointed out, cannot duplicate the uniquely valuable services which are made possible by the comparatively small mobile unit.)

PROCEDURES

Roentgenograms: Photographs are taken without moving the patient from his bed. The portable machine is set up in the patient's bedroom, and the board is slipped under the patient with a minimum of moving and virtually no discomfort to him. Diagnostic pictures of the chest and of the skeletal system are daily procedures. Since the pictures are developed right at the patient's house, we are sure they are of diagnostic quality before dismantling the equipment. If the picture is not satisfactory it is repeated. Although we rarely have to repeat a picture now that we have developed our technique, there is still an occasional photograph that does not come out well. By developing as we go along we save the time of returning for a repeat and also save the patient the discomfort of a second preparation.

Basal Metabolic Rate Determinations: Standard technique is used, with the added advantage that by bringing the basal metabolism testing unit to the patient's bedside, "basal" conditions are more nearly approached than by any other method.

Electrocardiograms: Twelve leads are taken with a direct writer, and the attending physician is called immediately—frequently from the patient's home.

Tranfusions, etc.: Blood for transfusion is obtained from the University of Cincinnati College of Medicine's blood bank at Cincinnati General Hospital. Standard intravenous solutions also are given whenever requested.

Blood Counts: When our mobile service was started, laboratory work was limited to emergency blood counts done at home. A microscope was set up in the kitchen and the necessary solutions were brought in. We still do such counts occasionally, but for the most part this service has been taken over by our central laboratory. One of the more common procedures is the prothrombin determination. The blood is drawn as often as required and the determinations are run in our central laboratory. This one procedure, performed as a home test, is very instrumental in bringing about the early discharge from the hospital of cases of coronary occlusion and of phlebitis.

RESULTS AND DISCUSSION

Convenience was to be the prime virtue of the mobile diagnostic service when it was started. But in our six years' experience, convenience—without diminishing—has become largely of secondary merit when compared with some of the unique advantages for patient and physician that the home service provides.

This applies in all of the wheeled laboratory's major functions: Roentgenograms, basal metabolic rate determinations, electrocardiograms, and laboratory procedures.

High quality x-ray films can be made with the portable machine after the technique is mastered. These "home-made" films have special value in cases of suspected fracture, in post-reduction fracture cases and in cases of suspected lung disease.

We often are called to take pictures of elderly persons to rule out hip fractures (these calls, in fact, are received more often than requests for any other type of roentgenogram). Many of these patients must be moved to a hospital for operative procedure after the fracture is diagnosed, but in many other cases no fracture is found, and the patient is made comfortable at home without putting him through the discomfort and expense of an unnecessary trip to the hospital. Also, there are many fractures which can be reduced at home if their true nature is established by roentgenograms.

Excellent films of the post-reduction hip fracture can be taken because the patients are able to offer full cooperation. The maintenance of good position and the progress of healing can be determined without obliging the patient to make an uncomfortable and tiring trip to a roentgenograph machine.

When lung pathology is established by the roentgenograms, the patient often need not be referred to a hospital. In most pneumonia cases, for instance, treatment can be carried out easily at home if the type and extent of the process are determined. The progress of the disease can also be followed with ease on films made in the home.

Differential diagnosis of an acute coronary occlusion seems to present more problems each year. At any rate, we are called upon to make tracings on many patients who present fairly "typical" syndromes, but whose serial tracings actually continue to be normal, so that another diagnosis is indicated. Most of these patients

do not require hospitalization if the necessary diagnostic tests can be performed at home. For that matter, I feel that most cases of proved coronary occlusion do not require hospitalization. Serial tracings can be taken at home, and if the physician feels that dicumarol® is indicated it can be given without danger as long as frequent prothrombin determinations are made (with establishment of our central laboratory we were, of course, enabled to offer service on prothrombin).

A patient with an uncomplicated acute coronary occlusion might, in routine practice, be hospitalized for a month or longer. But if follow-up electrocardiograms and periodic prothrombin determinations can be taken at home such patients often can be discharged from the hospital within two weeks.

Basal metabolic rate determinations do not come under the classification of emergency procedures, but they are most important and useful if done properly. Adequate rest and complete relaxation are requisites of a good test. His own bed provides the patient with the most restful sleep, and a large part of his apprehension is removed if the test is done in familiar surroundings.

To cite two cases: There was a young, very apprehensive mother who insisted that the mouthpiece always choked her and that she never had been able to "take a BMR test." But in her own bedroom, with her young child running about (and even crawling over the bed!), the patient was able to relax and complete the routine.

Another case was the elderly woman who went to the hospital, as an outpatient, for basal metabolic rate determination. This necessitated early rising, dressing, and a drive to the hospital. Her basal metabolism rating there was plus 65. Then the test was done again, but at her home after she had had a good night's sleep. The reading was minus 14!

CONCLUSIONS

It is felt that Hospital-Facilities-at-Home Service fills an important need in the community by providing necessary hospital services for those patients who are unable to go to a hospital, who prefer to remain at home, or who cannot be hospitalized because of shortage of beds. It also serves to alleviate the hospital bed situation by performing those basic procedures which are all that are required in many cases in order to institute proper treatment, and by the allowing of earlier discharge from the hospital of many patients.

For the physician it often expedites diagnosis, to the benefit of prognosis. Home service offers unique advantages in certain types of fracture, lung and coronary artery disease cases, and for determining basal metabolic rates. Such mobile services are especially commended to the attention of hospital prepayment plans.

State Problems in the Control of Garbage-Borne Diseases

The states that raise a minimum of the total hogs marketed in the United States are creating many problems and jeopardizing the entire livestock industry by the continued practice of feeding raw garbage to swine. This practice spreads trichinosis, hog cholera, vesicular exanthema, and even foot-and-mouth disease.

Practices of hog raising vary in different sections of the United States, and the problems of garbage-borne diseases vary with different states and sections of the country. The two main points to consider in controls affecting garbage-borne diseases of hogs are: (1) Is the state an exporter or importer of hogs and pork? and (2) is the state an exporter or importer of garbage?

Present interstate and state regulations pointed toward preventing garbage-borne diseases of hogs are ineffectual. Regulations addressed solely to the movement of raw garbage interstate are not sufficient to handle the problems of the states with regard to controlling garbage-borne diseases of swine. Controls must consider **garbage, hogs** and **pork**. The following regulations are recommended:

(1) Prevent the interstate movement of raw garbage except under certain specified conditions.
(2) Prohibit movement of live hogs and pork out of any state which shall fail to have and enforce regulations requiring the cooking of garbage that is fed to hogs.

It is pointed out that the success of any individual state's efforts to control these animal diseases rests squarely on the effectiveness of interstate controls.—Oscar Sussman, D. V. M., chief, Bureau of Veterinary Public Health, Division of Environmental Sanitation, New Jersey State Dept. of Health, Trenton, N. J.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

Amebic Colitis

In some areas, this is a very common cause of chronic diarrhea, since its incidence in the population varies from 10-40 per cent. The accurate diagnosis of this condition is very important, not only for the patient, but for others as well, since it is carried by contaminated food or drink and food handlers are, therefore, very dangerous. This condition may occur in children, too. Usually, it is seen mostly in men because of greater likelihood for exposure. While commonly not serious, it may occasionally develop serious complications, such as amebic hepatitis, amebic abscess of liver, perforation and intestinal hemorrhage, pulmonary lesions, brain abscess and intestinal granulomas that simulate carcinoma.—Frederick Steigmann, M. D., Chicago; *J. Indiana State M. A.*, 46:207, March, 1953.

Proceedings of the Ohio Society of Pathologists

Reported by WILLIAM SINCLAIR, Jr., M. D., Cleveland, Ohio

THE Spring Meeting of the Ohio Society of Pathologists was held at the Institute of Pathology, School of Medicine, Western Reserve University, 2085 Adelbert Road, on Saturday, May 23, 1953. The meeting proved to be one of the most successful held in Cleveland. More than seventy-five physicians were present, with good representation from all sections of the state.

SCIENTIFIC PROGRAM

The first portion of the scientific program was devoted to a symposium on cytology. Dr. James W. Reagan, assistant professor of pathology, Western Reserve University, Cleveland, opened the meeting with a discussion of the cellular diagnosis of malignant uterine neoplasms. The importance of securing an adequate specimen was stressed. Material should be obtained by cervical scrapings using a tongue blade or Ayre wooden spatula and by cervical aspiration using a clean, dry, glass pipette. The combination of both types of specimens provided the highest number of cases showing malignant tumor cells.

Aspiration of the posterior vaginal fornix may be used in addition but at least 10 per cent of such specimens from proved cases of carcinoma in situ failed to show tumor cells. This method, therefore, is not a substitute for the cervical specimens. Furthermore, before the specimen is to be collected the patient should be instructed to avoid douching for a period of 24 hours. Endometrial aspiration is not recommended for routine use, although this method is used experimentally.

In discussing the differential diagnosis of dysplasia (atypical hyperplasia) and carcinoma in situ, Dr. Reagan indicated that the cells in dysplasia are few in number, predominantly polyhedral in shape, occur in sheets having a regular pattern and the area of the nucleus is about one-third the size of the cell. Biopsy specimens show involvement of only portions of the thickness of the epithelium and some degree of normal stratification persists. In contrast, carcinoma in situ is characterized by large numbers of neoplastic cells. The cells are predominantly oval or round, occur singly or in syncytial masses and the nuclear area usually exceeds one-half the cell area. On biopsy, the full thickness of the epithelium is involved.

It was emphasized that the two processes cannot always be distinguished on cellular examination alone. Confirmation by biopsy should be obtained in these instances, as the cellular technique is not a substitute for tissue study but rather a complementary procedure. The tissue studies must be complete and detailed.

Cellular studies are of little value in the diagnosis of frank invasive carcinoma of the cervix but may be of value in following the effects of irradiation therapy. A characteristic feature of invasive squamous cell carcinoma, when present, is the so-called tadpole cell or elongated streamer cell. These occur in about 0.7 per cent and 1.0 per cent of cases respectively. More frequent and helpful is the presence of a macro-nucleolus which may indicate an aggressive or highly malignant tumor.

The usual features of neoplastic cells are sufficiently characteristic to permit diagnosis in over 90 per cent of cases. There are changes in chromatin pattern, marked enlargement of nucleus, hyperchromasia, pleomorphism of cells and nuclei, wrinkling of nuclear membrane, basophilia and rarely abnormal mitosis. Grading of tumors has not proved too successful or helpful.

Carcinoma of the fundus is characterized by small pleomorphic cells frequently found in clumps. Occasionally about such cells are large, ballooned cells containing glycoprotein. By themselves the balloon cells are not diagnostic of endometrial carcinoma, and are seen in carcinoma of the cervix. The accuracy of diagnosis in carcinoma of the fundus is 75 to 85 per cent. The postmenopausal woman who is bleeding is not a candidate for cell study. A diagnostic curettage should be performed.

CYTOLOGY OF BRONCHIAL SECRETIONS

The second paper was presented by Drs. L. J. McCormack and J. B. Hazard of the Cleveland Clinic. Their subject was "Experiences in Cytology of Bronchial Secretions." Bronchial swabbings are obtained and a wet technique is used as follows: (authors' summary)

Staining fluid:

(1.) Toluidine blue (histologic) (National Aniline) ..... 1 Gm.
Ethyl alcohol, 95% ..... 20 cc.
Distilled water ..... 80 cc.
Glacial acetic acid ..... 1 cc.
Mortar the dry stain with the alcohol and slowly add the water. Transfer the resulting solution to a glass stoppered bottle and add the acid.

(2.) Mix 10 cc. of the toluidine blue solution (1) with 20 cc. of serum.

(3.) Centrifuge to remove the sediment. The supernatant is decanted and comprises

Submitted June 12, 1953.

the staining fluid. It is kept in the icebox when not in use and is stable for months.

Preparation of slides:

(1.) Place a large drop of staining fluid on a clean glass slide.

(2.) Remove sponge, which was previously dipped in saline before use, from the bronchial sponge stick, grasping it tightly a few millimeters from the free margin with small forceps or snap. This serves to isolate the surface covered with bronchial secretion from the unimportant yet absorbent portion of the sponge.

(3.) Prepare suspension by triturating the free margin of the sponge in a drop of staining fluid on a glass slide.

(4.) Apply a cover glass.

It is customary to prepare the material remaining on the sponge for examination by smearing it on a glass slide, fixing immediately in acetic acid alcohol (95 per cent ethyl alcohol containing 3 per cent glacial acetic acid) and subsequently staining by the Papanicolaou method. This fixing agent has proved to remain stable after repeated usage and does not evaporate as does the commonly used ether-alcohol solution. It is filtered before reuse.

Since 1950, 506 patients have had a cytologic examination. Of this group, 170 cases (84 per cent histologically proved) were believed to have bronchogenic carcinoma, 45 per cent had a cytologic study positive for tumor cells on one examination. No false positive diagnoses were reported. The greatest diagnostic difficulties encountered were clumps of lymphocytes, basal epithelial cells and young macrophages.

Wet preparations are advantageous because of lack of distortion of cells due to smearing and absence of artifacts due to drying. The single important disadvantage is lack of permanency of the slides. The preparations should be studied as soon as possible though may be kept in the refrigerator as long as 24 hours if the cover glass is rimmed with vaseline.

NEOPLASTIC CELLS IN PLEURAL AND PERITONEAL FLUIDS

The third paper was presented by Dr. Janis Klavins and Dr. Nathan Kaufman of the Cleveland City Hospital. Their subject was the cytologic study of pleural and peritoneal fluids.

Fluid is centrifuged, serum is added to the sediment and the material is coagulated with a drop of topical thrombin, forming a mass which is embedded in paraffin in the usual manner. Cell block sections stained with hematoxylin and eosin are preferred to spreads if only one method is to be used. Both spreads and cell blocks are made at City Hospital in all cases. The spreads are stained with EA-50 standard Papanicolaou technique.

Problems in differential diagnosis include mesothelial cells which may form ring-like structures resembling acini. The general characteristics of neoplastic cells in pleural and peritoneal fluids were enumerated and are similar to bronchial and cervical neoplastic cells.

Discussion of each of the papers was opened by Dr. Emmerich von Haam, professor of pathology at Ohio State University. Some of the points brought out have been included in the foregoing summaries.

* * *

Abstracts of Cases from Slide Seminar

Moderator: Dr. John B. Hazard
Cleveland, Ohio

History abstracts and slides were sent to all members prior to the meeting for study and the final diagnoses represent the majority opinion of the Society.

Case 477. Dr. Arthur Rappaport, Youngstown Hospital, Youngstown.

A 58 year old white female with history of constipation for one year, fatigue for six months, and abdominal fulness for one week. Laparotomy disclosed a firm, lobulated, partially necrotic, solid mass measuring 15 by 17 by 10 centimeters which filled the entire pelvis and which extended to the level of the umbilicus. The mass appeared to arise from the right ovary. The left tube and ovary and the uterus were not remarkable. Postoperative x-ray therapy was given to the lower abdomen. The patient died three months after admission.

Autopsy disclosed an apparently retroperitoneal, abdominal, lobulated mass similar to the previous specimen. This weighed 4,500 grams, and numerous loops of ileum were adherent to the surface. There were pedunculated masses of tumor in the overlying parietal peritoneum, and the mesentery and serosa of the colon and small intestine contained tumor masses.

Microscopically, the tumor was composed of abundant, loose bundles of elongated, slightly pleomorphic cells in which cytoplasmic cross striations were readily apparent in most sections. Bizarre cellular forms such as so-called strap cells and tennis racquet-shaped cells were not present. In some areas the tumor was whorled, more fibrous, and the cells tended to be spindle-shaped. There were myxomatous areas. Fat stains were negative. The tumor was classified as rhabdomyosarcoma occurring in a mesenchymoma or mixed mesodermal tumor.

Diagnosis: *Rhabdomyosarcoma (In Malignant Mesenchymoma).*

Case 478. Dr. James Reagan, University Hospitals, Cleveland.

A 62 year old white female admitted with a swollen right arm. Seven years previously a right radical mastectomy for breast cancer was performed with no apparent recurrence of the tumor. Post-mastectomy lymphedema of the right arm developed which persisted but did not progress. Five weeks prior to admission she noticed bluish-gray, spotty discoloration and increased swelling of the right arm in the region of the

elbow which spread to the forearm, right anterior chest wall and mid-metacarpal region. The arm showed foci of gangrenous desquamation and gave off a foul odor.

Microscopically, the skin changes were characteristic of angiosarcoma or lymphangiosarcoma. There were abundant thin-walled vessels in the corium and subcutaneous tissue, foci of hemorrhage, necrosis, and inflammation. Thirteen cases have been reported following radical mastectomy.

Autopsy in the present case disclosed widespread metastatic carcinoma of the breast. There was no metastasis of the angiosarcoma but there was extension to the skin of the lateral chest wall. One case has been reported following radical mastectomy for a benign tumor. Apparently, carcinoma is not a predisposing factor. The interval between mastectomy and angiosarcoma has been seven to ten years. The terminology brought forth spirited discussion and the vote was cast as angiosarcoma with some favoring angioendothelialsarcoma, as the malignant cell is the endothelial cell. Lymphangiosarcoma was given consideration as this is the term usually used in the literature.

Diagnosis: *Angiosarcoma.*

Case 479. Dr. R. Dominguez, St. Luke's Hospital, Cleveland.

A white female, 49 years old, had exploration of right cerebellopontine angle and excision of a mass. Presenting complaint was intermittent tinnitus and progressive deafness of about three years duration.

Positive signs and symptoms were as follows: intermittent vertigo; dyspnea; sense of constriction of chest; occasional headaches on awakening with pain radiating from occiput to vertex; diplopia on looking to the left; spontaneous horizontal nystagmus with a slow component to the right, slightly intensified by left gaze; slightly sluggish right corneal reflex; widening of the right palpebral fissure and weakness of right orbicularis; flattening of right nasolabial groove; almost complete right nerve deafness; deviation of soft palate to the left on phonation; paralysis of right vocal cord; paroxysmal cough.

In summary, there was slight involvement of fifth, sixth, and seventh cranial nerves and marked involvement of eighth, ninth, and tenth. The eleventh and twelfth nerves were normal. At surgery an ovoid, firm, highly vascular mass 3.0 by 2.5 centimeters was found attached to the inner surface of the dura by a broad base, overlying the region of the right jugular foramen and extending to the internal acoustic meatus. It was necessary to cut the ninth and tenth nerves to remove the mass. Postoperative course was uneventful and the patient's general condition had improved when last seen three months after the operation, except for persistence of deafness on the right.

The tissue was composed of abundant, medium sized, acidophilic, occasionally vacuolated, polyhedral cells having eccentrically placed, prominent, hyperchromatic nuclei. The cells were arranged in groups and occasionally in an alveolar pattern. The stroma was richly vascular and there were broad bundles of fibrous tissue present. These tumors are like the carotid body tumor and the location frequently determines the choice of name. Their development is associated with cranial nerves and their ganglia and the vessels of the embryonic bronchial arches.

Diagnosis: *Non-Chromaffin Paraganglioma (Glomus Jugulare Tumor).*

Case 480. Dr. Francis Bayless, Deaconess Hospital, Cleveland.

The patient was a 53 year old welder who in the four days immediately before admission to the hospital had been making clambake steamers. Using an acetylene torch, silver solder welding rods, "Handy Flux" and stainless steel sheets, he welded sides, bottom and top to form a box-like steamer measuring 24 by 36 by 23 inches. He worked with his face partly inside the steamer to observe and follow the seams he had welded and did not use a mask. On the day before he was brought to the hospital he complained of headache, cough, shortness of breath and chest pain. These symptoms became more severe in the next 24 hours and he was admitted to the hospital with a diagnosis of lobar pneumonia.

On admission, he complained of severe chest pain. Examination revealed cyanosis, crepitant rales, increased bronchophony, dullness and bronchial breathing. Chest x-rays showed streaky, mottled and linear shadows of increased density scattered throughout the right lung field with similar changes in the left apex and subclavicular area. The temperature was 39°C., pulse 100, respirations 30, blood pressure 140/80. White blood cells 14,300, red blood cells 3.6 million, hemoglobin 78 per cent. The urine albumin was 1 plus. Smears of sputum were negative for acid-fast organisms. There was steadily deepening cyanosis, hemoptysis, tachycardia, rapid respiration, persistent fever and intermittent profuse perspiration. Death occurred 44 hours after admission to the hospital.

At autopsy the lungs were heavy and weighed 750 grams and 1200 grams. Random microscopic sections of the lungs were similar and the essential features were marked intra-alveolar edema and hemorrhage, multinucleated cells, and focal detachment of alveolar epithelium. Foci of epithelial proliferation were present and were considered evidence of early epithelial regeneration. The liver showed fatty metamorphosis and there was capillary thrombosis of some of the renal glomeruli.

The changes in the lungs were typical of cadmium fume poisoning. The silver solder used is an alloy of silver and cadmium in which the percentage of cadmium may vary from 5 to 80 per cent. The classical clinical features are onset 24 hours after exposure, intense chest pain and fever. The mortality rate is 20 per cent. Cadmium fume poisoning may occur in welding or salvage operations.

Gastrointestinal disturbances have been reported from ingestion of cadmium contaminated food due to refrigerator trays from which cadmium plating has dissolved. These cases are usually not fatal. It is illegal in some states to plate food utensils with cadmium. The home solder rod usually contains cadmium. A positive pressure face mask is strongly recommended while using home solder.

Diagnosis: *Fume Pneumonitis (Cadmium).*

Case 481. Dr. William Morningstar, Crile V. A. Hospital, Parma.

A 56 year old white male who has had a chronic cough productive of a thick white sputum and progressive dyspnea for the past 10 years was admitted with marked dyspnea and cyanosis. He had had three previous admissions to this hospital. On his first admission about one year ago, the pulmonary vital capacity was two liters,

or 44 per cent. All chest x-ray examinations revealed marked, diffuse, bilateral pulmonary fibrosis with large and thin trabeculae and round, cystic, radiolucent areas. For the past 29 years his occupation has been in the curing room of a rubber factory, making tires. It was very dusty and soapstone and lamp black were used.

The essential postmortem findings were confined to the heart and lungs. There was a cor pulmonale and chronic adhesive pericarditis. The lungs weighed 1900 gm., were firm, and on section consisted of dense, pale gray to black, interlacing fibrous strands and masses which varied from 0.1 to 1.0 cm. in width and which were most marked in the upper lobes. Between these strands, the air spaces were large. There was bilateral fibrous obliteration of the pleural cavities.

Soapstone is a mixture of aluminum and magnesium silicate. The changes in the lungs are not those commonly associated with silicosis. The process involves chiefly the mid-portions of the lungs and is associated with marked pleural reaction. Microscopic sections showed diffuse and focal interstitial fibrosis without whorling. In the fibrous tissue were crystals shaped like rhomboid plates which with polarized light were refractile and subsequently proved to be mostly mica with small amounts of talc. Mica is aluminum silicate. The changes thus are attributed to silicate, not silica.

Diagnosis: *Pneumonoconiosis (Silicate).*

Case 482. Dr. L. J. McCormack, Cleveland Clinic, Cleveland.

A 70 year old engineer was admitted because of episodes of unconsciousness of seven months' duration. These usually occurred before breakfast, and less frequently two to four hours following meals. Prompt relief was achieved by eating. A weight gain of 25 pounds was noted. Physical examination revealed a palpable upper abdominal mass. The blood pressure was normal. A blood sugar level during an attack was 25 mg. per 100 cc. Other laboratory determinations were normal. At laparotomy a large, irregularly shaped, partially encapsulated tumor mass, weighing 10.4 kilograms was removed from the lesser omental cavity. The cut surface presented areas which showed marked whorling of firm, grayish-white tissue. Other foci were soft and gray.

A portion of the tumor was removed at surgery. No pancreatic tissue was removed, and the tumor was not clearly established as arising from pancreas. The hypoglycemia disappeared following surgery. Determinations were not made to see if the tumor contained insulin. Some tissue was planted in a guinea pig's eye and is still growing but nothing definite can be stated about its insulin producing character. The left lobe of the liver was flattened over the tumor mass, suggesting the tumor had been present for a long time.

Microscopically, the tumor was composed of abundant spindle cells, with large amounts of reticulin and many edematous spaces present. Mitoses averaged 3 to 4 per high power field. The tumor appeared to be a fibrosarcoma and was considered malignant. The question arose as to the possibility of this tumor being an insulin producing tumor or a glucose utilizing tumor of high metabolic activity. A follow-up report will be made to the Society in one year.

Diagnosis: *Malignant Spindle Cell Tumor with Hypoglycemia.*

Case 483. Dr. Harold Gold, Mt. Sinai Hospital, Cleveland.

A 17 year old male was admitted with chief complaints of convulsions, amnesia, and headache of four days' duration. He was moderately dehydrated, emaciated, and appeared quiet and depressed, though not confused. Fourteen months prior to the present illness he developed upper respiratory infection with loss of weight. Tuberculosis was ruled out, but chest x-rays showed migrating pulmonary infiltration. Lymph node and muscle biopsies were negative. He was treated with ACTH a year before death with apparent remarkable recovery. A month after discharge he developed asthma and was desensitized to various allergens. The spinal fluid contained crenated red blood cells. Reaction to the Pandy test was 4 plus. The peripheral blood hemoglobin was 11.3 gms, red blood cell count 3.96 million, and the differential disclosed 27 segmented polymorphonuclear leukocytes, 15 lymphocytes, and 57 eosinophils. The patient died five days after admission.

Autopsy revealed recent hemorrhage in the left occipital lobe measuring 1.5 cms. in diameter. In the heart and liver were numerous poorly defined red and yellow foci varying from 0.5 to 2.5 cms. in diameter in the heart and to 4 cms. in diameter in the liver. The lungs contained finely nodular, firm zones.

Microscopic sections of the heart showed several well-defined zones of fibrinoid degeneration and necrosis surrounded by large palisading epithelioid or spindle cells. There were many eosinophils, lymphocytes, and neutrophils in the interstitial tissues as well as abundant macrophages containing hemosiderin. Small blood vessels were involved. The character of the inflammation was considered clearly allergic. The sensitizing agent was not defined.

Diagnosis: *Allergic Granulomatous Myocarditis and Angitis.*

Case 484. Dr. P. W. Graff, St. Vincent's Charity Hospital, Cleveland.

The patient was a 64 year old white male who had resection of carcinoma of sigmoid colon in 1950. He was readmitted in March 1953. A thoraco-abdominal laparotomy was performed and a retroperitoneal, nodular, encapsulated tumor mass weighing 1,067 grams was removed. Two periaortic lymph nodes containing tumor were also removed as well as a segment of lung containing metastatic tumor. The left kidney and spleen were removed, but were free of tumor. The patient died on the fifth postoperative day. Autopsy disclosed widespread metastatic carcinoma. The left adrenal was identified in a mass of tumor and was distorted.

Microscopic sections showed sheets and cords of large, polyhedral, pleomorphic cells. The nuclei were huge. Multinucleated tumor giant cells were present. It was concluded that this patient had two primary tumors. The tumor submitted and producing metastasis was considered to arise in the left adrenal.

Diagnosis: *Adrenal Cortical Carcinoma.*

Case 485. Dr. E. Goodsitt, Huron Road Hospital, Cleveland.

A 78 year old white male was admitted because of obstipation for six months. A 50 pound weight loss had occurred in the last two years. Physical examination disclosed a large, non-tender, soft mass in the right upper quadrant of the abdomen which extended to the right iliac crest

and to the left side of the abdomen 5 cms. below the costal margin. Laboratory studies showed hypochromic anemia, slight azotemia, normal fasting blood sugar and normal serum proteins. The patient died on the third hospital day. At autopsy a mass measuring 12 cms. in diameter replaced the tail of the pancreas and infiltrated the stomach and the hilus of the spleen. The liver contained metastatic tumor.

Microscopic sections of the spleen disclosed well defined masses of tumor composed of cells resembling the islet cells of the pancreas. The diagnosis was unanimous. These tumors are rare.

Diagnosis: *Malignant Islet Cell Tumor.*

Case 486. Dr. D. B. Hackel, Cleveland City Hospital.

A 31 year old Negro woman entered the hospital in December 1951 complaining of progressive impairment of vision for three years, and a 30 pound weight loss in the last year. Her pupils were fixed and did not react to light. The optic discs were chalky white. A single serologic test for syphilis was positive and a presumptive diagnosis of luetic optic atrophy was made. During the next few months in the hospital she developed increasing somnolence. A pneumoencephalogram showed a globular, expanding lesion encroaching on the third and lateral ventricles. Craniotomy was performed. She died three months later in July 1952.

Microscopic sections showed sheets of large, acidophilic, polyhedral cells having abundant granular cytoplasm and small nuclei. No mitoses were observed. At the periphery the capsule was fibrous and showed old hemorrhage. There was no invasion.

Diagnosis: *Granular Cell Tumor of Neurohypophysis.*

Psychiatry and Religion

Psychiatry, a medical specialty responsible not only for half of the country's hospitalized patients but for the neurotics of all kinds and description whose number is legion, in some areas, until recently, was under suspicion.

The discourse of Pope Pius XII, September 13, 1952, outlined the moral limits of research and treatment. It set forth briefly the essential principles and left the application in specific cases to the doctor. "Because only the doctor understands the medical evidence thoroughly, both in itself and in its effects, and because without expert knowledge of the medical facts it is impossible to determine what moral principle applies to the treatment under discussion. The doctor therefore looks at the medical aspects of the case, the moralist the laws of morality." In this allocution the morality, the efficacy, and the correctness of the pan-sexual method of a certain school of analysis are denied. Most psychiatrists would have no trouble in agreeing with this pronouncement and this extreme school has had few adherents in late years.—Francis J. Braceland, M. D., Hartford, Conn.: *Minnesota Medicine,* 36:711, July, 1953.

Auricular Fibrillation

It is now well established that auricular fibrillation is a serious disorder of the cardiac rhythm. When this arrhythmia develops in the heart the patient is laid liable to certain complications that will be either disabling or possibly lethal. The three most important of these are congestive heart failure, which may be ushered in by auricular fibrillation, peripheral or pulmonary embolus, or important psychiatric reactions which commonly develop as a result of the disturbing tumultuous palpitation.

Two types of auricular fibrillation should be recognized. The first is that associated with organic heart disease. Chronic rheumatic mitral valvular disease has long been known as the precursor of auricular fibrillation. Coronary arteriosclerotic heart disease with myocardial fibrosis—with or without hypertension—is another.

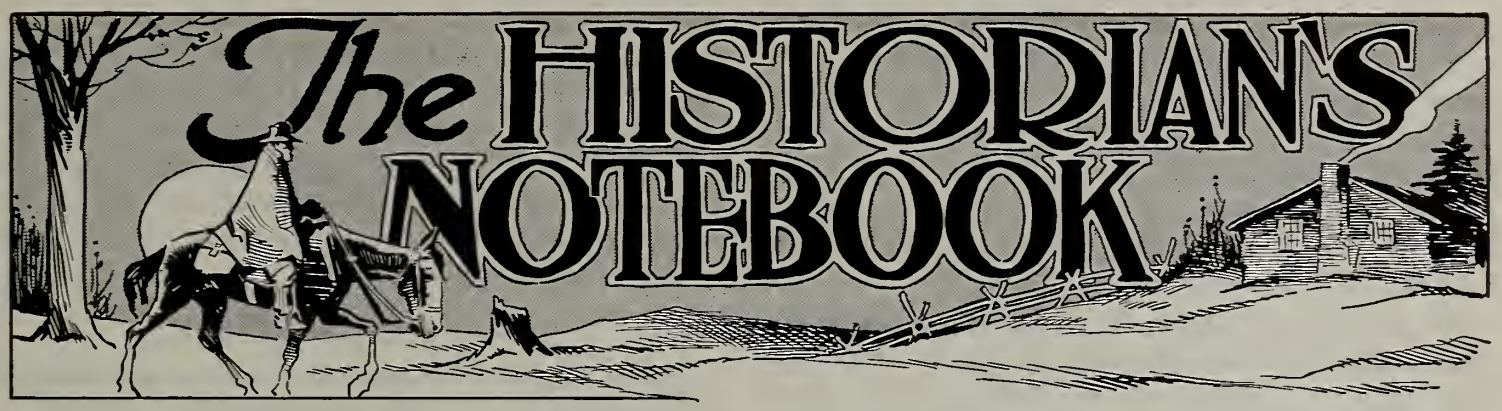
The so-called thyrotoxic heart disease is frequently accompanied by auricular fibrillation, although it should be recognized that specific underlying cardiac lesions are present before the onset of thyrotoxicosis.

Auricular fibrillation often occurs in hypertensive heart disease. It is unusual for this arrhythmia to occur in isolated aortic insufficiency due to syphilis of the aortic valve, but it does occasionally develop in patients with isolated rheumatic aortic involvement. This group encompasses those patients with the greatest incidence of auricular fibrillation, and it is noted that all save a small percentage in the thyrotoxic group have organic heart disease.

The second type of patient who has auricular fibrillation is rather unusual but not unimportant. This is the rare individual who, without any demonstrable cardiac lesion, presents auricular fibrillation. The bulk of these patients give a history of paroxysms of tachycardia. Careful questioning reveals that the patient noted the heartbeat to be irregular. Often the fibrillation may be observed and recorded by the electrocardiograph.

That this dysrhythmia should be considered lightly is untrue, since we have observed peripheral emboli and, with a long paroxysm the development of cardiac enlargement and failure in paroxysmal auricular fibrillation on several occasions.

Patients with auricular fibrillation, while divided into two classes, therefore become of unusual importance—although those with chronic auricular fibrillation present in greater degree the problems of embolism and cardiac failure than do those with paroxysmal auricular fibrillation.—Robert L. McMillan, M. D., Winston-Salem, N. C.; *J. M. A. Georgia,* 42:82, February, 1953.



Medical Journalism in Ohio

JONATHAN FORMAN, M. D.*

PART II

(Concluded from August issue)

AT the Annual Meeting of the Ohio State Medical Association in Columbus in 1905, the establishment of a journal to take the place of the transactions was authorized. But this journal was to be more than an installment of the proceedings of the Annual Meeting. There is much evidence to bear out the thesis that the desire of the Association was to effect a means of interorganizational communication. Perhaps the 1905 report of The Council expressed this best:

"As has already been told you by our President in his address—as was also advocated by ex-presidents Brush, Chapman, and Hamilton—we are greatly in need of a Journal of Organization. This is altogether a different thing from a mere medical journal of the Association. While it would publish all transactions—papers and discussions too—it would also contain news from the county medical societies and their transactions. It is the unanimous opinion of those who have investigated this matter that an Organizational Journal is essential. It is the only way by which we can keep in touch with each other and keep posted as to the needs and conditions of the profession throughout the state.

"Some twelve or fifteen other states are already publishing journals and their testimony is that they are doing so successfully. Proprietary medical journals have neither the time nor the space that can be diverted to our interests. It is hardly necessary to dwell upon this fact. This Association has not the right to control the editorial and advertising columns of a private journal. As one proprietor told The Council when we were investigating this subject a year ago—'No proprietary can live that does not advertise patent nostrums.' What a farce for physicians to subscribe to journals that are continually clubbing them to death."

THE SET-UP

The Ohio State Medical Journal was set up under the direct and editorial supervision of the Publication Committee. All officers and committeemen, then as now, were volunteer workers. From the beginning *The Journal* was a success, carrying as it did some thirty pages of advertising.

Soon we find *The Journal* embarked on a campaign for a law providing for adequate registration of births and deaths; for improvement in the milk supply of Ohio towns and cities; for the control of the sale of cocaine; for the improvement of the organizational structure of county medical societies; and for the exposure of quacks and patent medicine advertisements.

The establishment of the Ohio State Industrial Commission with its Workmen's Compensation Fund, the activity of the cults, and the general trend to organize and centralize, moved the Association to set up an office with full-time help.

THE AUTHOR'S PART

In December, 1935, there began a series of historical sketches edited by the author in a new department, "The Historian's Notebook." All the other departments had disappeared, by the way, except comments on organizational matters by the Executive Secretary, but these were now modestly uttered in "In My Opinion" and placed in the back of the magazine.

"The Historian's Notebook," contributed by a

*Professor of the History of Medicine in the Ohio State University, Columbus, Ohio.

Read before the joint meeting of The American Association of the History of Medicine and The Ohio Academy of the History of Medicine at Columbus, Ohio, on April 11, 1953.

small group of physicians, has appeared regularly. Through the years there have accumulated more than 130 articles on local medical history. These have received national recognition and, together with the fall issue of the *Ohio State Archaeological and Historical Quarterly*, have been of great help to the students of Ohio medical history.

On February 2, 1936, The Council of the Ohio State Medical Association appointed the author to be the editor of *The Ohio State Medical Journal*. *The Journal* from that day on we shall leave for some future historian to describe.

Only one new feature of *The Journal* under the present editorship will be mentioned i. e., there is a brief notice of practically every book published in medical and allied fields, in sociology and economics dealing with medical care or sickness, nutrition, all fiction having a physician, dentist, or nurse in its cast or a hospital for its locale, all books on dentistry having medical implications, books on nursing and public health, as well as those of poems by physicians. These are designed to aid the reader in selecting books for his own and his hospital's library. Consequently, they appear months before reviews in other magazines designed perhaps to educate authors.

CLINICAL WORK

So, throughout its existence, *The Ohio State Medical Journal* has attempted to contribute to medical progress in Ohio by making itself the medium for disseminating a wide variety of information for the benefit of the members of the Ohio State Medical Association. It has attempted throughout the years (successfully, I believe) to help the Ohio physician keep himself well informed on all phases of clinical medicine. It should never be forgotten that a committee of leaders in the profession have always arranged the programs of the Annual Meetings of the Ohio State Medical Association and have in this way assured that the bulk of the clinical papers published in *The Journal* would be more timely and varied than any editor by himself could possibly have selected.

The Journal has likewise been faithful to its big assignment when it began back in 1905, which was to serve as a journal of organization. Its work in this direction has been apparent at each Annual Meeting and has always met with approval. It has served as a pathway for interorganizational communication. It has kept the physician informed of the changing social order. As we as a people have demanded more and more service of our government—especially the Federal government since its services always appear to be free—the number of laws, directives, and regulations that have come to pester the physician in his working hours have been gathered and interpreted for him. The social and economic legislation, court decisions, and industrial factors that nowadays affect, mostly unfavorably, the life of every Ohio physician have been as fully recorded as is humanly possible. To report all of these things promptly to the physicians of Ohio has been and is, and in my opinion, always will be the first job of *The Ohio State Medical Journal.*

WE ARE NOT SCIENTISTS

In my series of twelve lectures on the history of medicine here in the Ohio State University, I try to use the story of the past to orient the freshmen in Medicine. We try to make each of them conscious of the fact that the medical man is not a scientist but an artist who uses the facts which the applied scientist have taught him, to help Nature in the cure of the sick and wounded.

The important thing for each of us to remember is that it is our obligation as healers to stay within the biological "norm" for Man. We must therefore understand the ecology of health lest we do more harm than good with our theories and our crude tools and our systems of healing based, as the best of them is, upon the flimsiest of assumptions.

As to the future, I try to prepare students to realize that whatever progress the healing arts will make, will depend upon what those engaged in research in chemistry, physics and mathematics can bring to the applied sciences of anatomy, pathology, bacteriology, immuniology, and biochemistry in all of its branches. I try, also, to give them a glimpse through the eye of the past into social pathology, that they may be assured that their chosen profession is intimately woven into the social fabric and, therefore, what they and their colleagues do will have a profound effect on Society and what Society does to them it must do to Society as a whole. So if they are afraid of being taken over by the State rest assured that all will suffer from Statism.

This paper amplified with details to illustrate these points is in my humble opinion a good illustration of the material available in the history of medicine in Ohio to teach these important points and so to orient the young people coming into medicine as to the place of the healer in society.

A Check List of the Medical Periodicals Which Have Been Published in Ohio

1822-1823—*Western Quarterly Reporter of Medical, Surgical, and Natural Sciences.* Vol. 1 and Vol. 2, Nos. 1 and 2. Cincinnati.

1826-1827—*The Ohio Medical Repository of Original and Selected Essays and Intelligence.* Cincinnati. Published by Guy Wright and J. M. Mason. Merged with the next item in 1828.

1827-1828—*Western Medical and Physical Journal.* Published by John D. Godman.

Vols. 1 and 2. Then merged with the next above to form—

1828-1838—*The Western Journal of Medical and Physical Sciences,* Cincinnati, to complete 12 volumes, then united with Louisville Journal of Medicine and Surgery to form *The Western Journal of Medicine and Surgery.*

1832-1835—*The Western Medical Gazette,* Cincinnati, Vols. 1-2. Then was merged into the next above.

1832-1835—*Eclectic Journal of Science.* Columbus, Vols. 1 and 2. Changed to *Eclectic and Medical Botanist* in 1833.

1832-1837—*The Thomsonian Recorder.* Columbus. Edited by Alvin Curtis to carry on as *The Botanico-Medical Recorder* (1837-52); then as *Physio-Medical Recorder* (1852-80); then *The Cincinnati Medical Gazette and Recorder* (1880-83); *Cincinnati Medical Record* (1883-84).

1835-1836—*The Ohio Medical Repository.* Cincinnati. Vol. 1.

1836-1837—*The Eclectic Medical Journal.* Worthington and Cincinnati. Vols. 1-7. Called *The Western Medical Reformer* and published at, and by the faculty of, the Reformed Botanic Medical College in Worthington; was suspended in 1838 until revived in Cincinnati 1844.

1837 —*Western Quarterly of Practical Medicine.* Cincinnati. Vol. 1, No. 1.

1842-1916—*Western Lancet* (title varies). Vols. 1-18 (1842-1916).
Cincinnati Lancet and Observer. Vols. 19-39.
Cincinnati Lancet and Clinic. Vols. 40-55.
Cincinnati Lancet-Clinic. Vols. 56-92.
Cincinnati Medical Observer, Vols. 1 and 2 (1856-57), united with Western Lancet to form—

1848-1864—*The Ohio Medical and Surgical Journal.* Vols. 1-16. Columbus. Published for and by Starling Medical College. Dean John Butterfield, editor. Upon his death Hanbury Smith succeeded. Later passed into private hands (faculty member, however).

1851-1852—*Cincinnati Journal of Homeopathy.* Cincinnati.
Cincinnati Medical Advance (see *Chicago Medical Advance),* a monthly homeopathic magazine.

1855-1856—*The Medical Counselor.* Vol. 1, Nos. 1 and 2, Jan. 6, 1855, to June 28, 1856. Columbus.

1858-1859—*Cincinnati Medical News.* Dedicated to the Dissemination of the Truth. Cincinnati. Vols. 1 and 2, to be followed by *Cincinnati Medical News,* to become in 1860 *The Cincinnati Medical and Surgical News.* Ceased publication in 1863.

1858-1860—*The Belmont Medical Journal.* Bridgeport, Ohio. With transactions of The Belmont County Medical Society for 1847-1877, makes 3 volumes.

1859 —*Cincinnati Eclectic and Edinburgh Medical Journal.* Cincinnati. Vol. 1, Nos. 1-11.

1859-1861—*The Cleveland Medical Gazette.* Contents identical with the Cincinnati Lancet and Observer. Cleveland.

1860-1861—*Columbus Review of Medicine and Surgery.* Columbus. Vol. 1, Nos. 1-5.

1867-1877—*The Ohio Medical and Surgical Reporter.* Cleveland. Homeopathic.

1868-1871—*The Cincinnati Medical Repository.* Vols. 1-4. Taken over by—

1872-1891—*Cincinnati Medical News.* A continuation of *The American Repository.*

1876-1878—*The Ohio Medical and Surgical Journal.* Columbus. New series Vols. 1-3. Revived at the time Starling Medical College got out of debt.

1876-1881—*The Ohio Medical Recorder.* Vols. 1-5. Vol. 1 published (1881-1882) when its name changed to and was superseded by—

1882-1916—*The Columbus Medical Journal.* Vols. 1-40. Fell prey to the attack on secret remedies and became house organ for the *Peruna Company,* with Dr. Carr as editor.

1877-1880—*The Cincinnati Medical Gazette.* Cincinnati. Merged into The Physio-Medical Recorder to form *The Cincinnati Medical Gazette and Recorder*; later called *Healthside.*

1877-1883—*The Toledo Medical and Surgical Journal.* Vols. 1-5. Toledo. Absorbed by *Toledo Medical and Surgical Reporter.* Editors—Jonathan Priest, W. Chapman and Thomas Wendell.

1879-1881—*The Ohio Medical and Surgical Review.* Published by The Mahoning County Medical Association, Vols. 1 and 2.

1884 —*American Medical Compendium.* Toledo.

1884-1910—*The Medical Compendium.* Vols. 1-5. *The Toledo Medical Compendium.* Vols. 6 - 10. Suspended 1886-88, Vols. 6 and 7 omitted then in numbering. Editors—Jonathan Priest and H. G. Blaine.

1885-1896—*The Cincinnati Medical Journal.* Cincinnati. Began as *The Cincinnati Medical and Dental Journal,* Vol. 1, Nos. 1-3, then name was changed.

1885-1901—*The Cleveland Medical Gazette.* Merged with *The Cleveland Journal of Medicine.*

1886 —*The Ohio Medical Journal.* Mansfield. Vol. 1, No. 1.

1888-1900—*The Toledo Medical and Surgical Reporter.* Vols. 1-36. Merged into

American Medical Compendium (1884-1910).

1889 —*The Medical News.* Vols. 1-5. Orrville.

1889-1912—*The Eclectic Medical Gleaner.* Vols. 1-15. (1905 new series to 1912)

1890-1898—*The Ohio Medical Journal.* Vols. 1-9. (1890-91 *Medical College of Ohio Journal*).

1893 —*The Cincinnati College of Medicine and Surgery Archives.* Reprinted from Cincinnati Medical Journal.

1893-1895—*The Medical Indicator.* Vols. 1-3. Cleveland. Vol. 1, Nos. 1 and 2 as *The Indicator.*

1893 to date—*The Woman's Medical Journal.* Cincinnati.

1896-1901—*The Cleveland Journal of Medicine* (Cleveland Medical Society). Was first called *The Western Reserve Medical Journal.* Merged with *The Cleveland Medical Gazette* to form—

1902-1918—*The Cleveland Medical Journal* (Academy of Medicine).

1897-1898—*The Cincinnati Academy of Medicine Transactions.*

1899-1906—*Medical Talks for the Home.* Columbus. Vols. 1-7 (1899-1906). 1899-1902 as *Medical Talks;* then merged with *Health* (N. Y. C.).

1900-1901—*The Cleveland Homeopathic Reporter.* Merged with *The Ohio Medical and Surgical Reporter.*

1903 —*The Medical Educator.* Columbus. Vol. 1, Nos. 1, 2 and 4. No. 3 never published.

1905 to date—*The Ohio State Medical Journal.* Columbus. Vols. 1-49. Official publication of The Ohio State Medical Association since its organization from The Ohio State Medical Society.

1911-1918—*The Cincinnati Academy of Medicine's Weekly Bulletin.*

1914-1915—*The Cincinnati Medical News.* Vols. 1 and 2. Cincinnati. Vol. 1, Nos. 1-5 as *The Medical News.*

date ? —*The College Journal of Medical Sciences.* Cincinnati.

1920 —*The Cincinnati Journal of Medicine.* Vol. 34. The Official Publication of The Cincinnati Academy of Medicine.

1928-1939—*Cincinnati Herald of Health.* Cincinnati. Vols. 1-9.

Mass Chest X-Ray Surveys

Mass chest x-ray surveys, originally intended to detect early pulmonary tuberculosis, have also revealed that other intrathoracic lesions may be found with some degree of frequency in apparently healthy people.—Sidney E. Wolpaw, M. D., *Annals of Internal Medicine,* September, 1952.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Debauch—This term which now refers to intemperance, to lewdness, or means to corrupt, originally meant a cessation of work or idleness. It came into English via the Old French term "desboucher" which meant to mar or corrupt. This term is composed of the French word "des" meaning away or from, plus "bauche" a shop. Hence the term literally meant to lure a person "away from his shop" so as to have him indulge in idleness, drinking or other vices.

Deliver—Coming from the Latin words "de," or from, and "liberare" to free, this term literally means "to free from something" as for example, "to free or deliver a woman of a child."

Diagnosis—An ancient Greek word meaning, "a judging or a deciding." This word is composed of the Greek "dia" or through, plus "gignosko" I know.

Diaphragm—Composed of the Greek prefix "dia" meaning through, over or across, and the Greek word "phragmos" meaning a hedge, or fence, this term was originally applied by the ancient Greeks to any septum of the body. Celsus in his "De Medicina" written in about 30 A. D. used the term to designate the abdominal diaphragm. The ancients erroneously believed the diaphragm to be the seat of the mind, and it was not until the 16th century that its functions were correctly explained by Fabricius.

Fee—This term designating a price paid for services is now generally applied to the charges of professional men. However, it is an ancient term which comes from the Anglo-Saxon word "feoh" or cattle and stems back to the days before the use of money, when cattle were used as a means of payment.

Femur—Now designating the thigh-bone this Latin word formerly designated the entire thigh and is derived from the Latin word "fero" meaning to bear. However the term does not refer to bearing the weight of the body, but was used in the sense of "fero" to bear and "fertus" to be borne. These words all probably stem from "feo" meaning to be fruitful or fertile and relate to the functions of the thighs to sex and the bearing of children.

Gaultheria—The plant Gaultheria procumbens, or wintergreen, the leaves of which yield a volatile oil. This plant was named after Jean Francois Gaulthier an 18th Century Canadian physician and botanist.

Gawky—Meaning awkward or foolish this term is a corruption of the French word "gauche" or left. Hence to be "gawky" is literally to be left-handed or awkward and thus foolish.

—Harry Wain, M. D., Mansfield, Ohio.

Legislative Review . . .

Work of Ohio General Assembly, Which Adjourned on Aug. 7, Summarized; Digest of Medical-Health Bills Enacted; Comments on Proposals Defeated

AN exceptionally good record on medical and public health legislation was chalked up by the 100th Ohio General Assembly which adjourned sine die on August 7.

Under the able leadership of Speaker William Saxbe, Mechanicsburg, in the House, and of President Pro Tem C. Stanley Mechem, Nelsonville, in the Senate, the Republican-controlled General Assembly operated for the most part in a smooth, efficient manner, and did a constructive job.

During the session which lasted a few days longer than seven months, the General Assembly enacted 292 bills out of a total of 1,178 introduced. It overrode nine bills vetoed by Governor Lausche and sustained his veto of four bills.

MANY MEDICAL-HEALTH BILLS

Approximately 75 measures considered by the Legislature had a bearing on medicine or health, directly or indirectly. These were followed carefully by representatives of the Ohio State Medical Association. The Association gave active support to many of them. It actively opposed some of the bills on the grounds that their enactment would be detrimental to the interests of the people of Ohio.

No bill actively opposed by the Ohio State Medical Association was enacted. This indicates sound judgment on the part of the majority of the membership of the General Assembly, and reflects the efficient work done by the officers and legislative chairmen of the County Medical Societies, members of the state Legislative Committee, and representatives of the Columbus Office.

DID OUTSTANDING JOB

An outstanding job was done by Mrs. Opal Mundy, Toledo, chairman of the House Health Committee; the vice-chairman of that Committee, Harold W. Oyster, Marietta; and Senator Charles A. Mosher, Oberlin, chairman of the Senate Committee on Education and Health. The majority of the bills in which the medical profession was directly interested were heard by those two committees. The hearings were conducted in a fair, impartial manner and representatives of all groups or organizations were given ample opportunity at all times to be heard and to submit testimony.

Credit for constructive work and sound judgment also is due the majority of the members of those two hard-working committees. On only one occasion did the House Health Committee stub its toe, and then by a margin of only one vote. By a vote of seven to six it reported out and recommended for passage the chiropractic bill which, later, was defeated on the floor of the House. Otherwise, the record of the committee was A-1. The Senate committee batted 100 per cent consistently.

DESERVE CREDIT

Other members of the House Health Committee who supported the viewpoint and policies of the medical profession at all times on measures before the committee were: Representative Crowl, Dayton; Hayden, Felicity; Woods, Scioto; and Sawicki, Cleveland.

In additon to Senator Mosher, members of the Senate committee, which did an excellent job on medical-health matters, were: Senators Collins, Ironton, vice chairman; Pollock, Canton; Humphrey, Ashtabula; Hoffman, Cincinnati; Pepple, Lima; Shaw, Columbus; Bernard, Youngstown and Corrigan, Cleveland.

RIGHT ATTITUDE PAID DIVIDENDS

Those who represented the medical profession, on a state or local basis, during the legislative session and who conferred frequently with legislators on medical and health questions won many friends for the profession among the members of the General Assembly because of their constructive attitude on pending measures; willingness to cooperate with members of the Assembly in redrafting proposals which were sound in principle but poorly or loosely worded; and forceful, logical arguments in opposition to proposals which they felt would be detrimental to the health and welfare of the public.

Unfortunately, the Assembly did not enact a few measures which had the endorsement of the Ohio State Medical Association but most of the bills which carried that endorsement were passed.

Following is a list of medical-health bills or measures of special interest to the medical profession, enacted into law:

THESE MEASURES WERE ENACTED

S. B. 12, to permit a city health district to contract with the advisory council of a county health district for public health services. Effective Oct. 2.

S. B. 33, authorizing the Attorney General with the assistance of other governmental agencies and private organizations to make a study of the

existing laws relating to the control of narcotics; to evaluate present law enforcement, penal and rehabilitation procedures and the adequacy thereof; and to make recommendations for changes in the narcotics laws and procedures. Became effective July 10.

S. B. 41, permits the State Tuberculosis, Ohio State University Health Center, to retain non-tuberculosis patients for a reasonable time after diagnosis of non-tuberculosis is made to permit patient to make proper arrangements for hospitalization of ailment, if necessary, in another institution.

S. B. 76, provides for a Commission, with full time staff and consisting of designated members of General Assembly and appointees by the Governor to take over the activities and functions of the Ohio Program Commission, State Bureau of Code Revision, and the Legislative Research Commission; a research and fact-finding agency on subjects and questions referred to it by the General Assembly and to prepare reports on proposed or pending legislation for the General Assembly. Effective Sept. 16.

S. B. 81, provides for admission of blind children to special classes for education when attaining an age of three years. Effective Oct. 2.

S. B. 87, raises the ceiling on monthly aid to the blind from $60 to $65. Effective Oct. 21.

S. B. 108, increases from one year to three years the residence requirement in Ohio to qualify for poor relief. Effective Oct. 16.

S. B. 130, permits a township to enter into agreement with a city for the erection and management of a hospital. Effective Oct. 2.

S. B. 131, provides for excluding part of a township lying within a municipality from participation in a joint township hospital district. Effective Oct. 2.

S. B. 138, amends the Ohio Civil Defense Act by making it easier to form county-wide Civil Defense organizations; provides a way for two or more counties to join in organizing a district or regional Civil Defense program; provides political subdivisions, agencies, organizations and individuals with exemption from liability for injury, death and property damage in carrying on Civil Defense activities unless guilty of willful misconduct; provides specifically that persons injured or killed, or whose property is damaged, as a result of Civil Defense activities are entitled to benefits and compensation already provided for under existing laws, such as Workmen's Compensation, pensions, and general municipal laws; extends to persons from other states participating in Civil Defense activities in this state, under mutual aid and assistance agreements between states, the immunities and privileges they would ordinarily possess if performing their duties in their own state.

S. B. 155, creates a new State Department of Mental Hygiene and Correction; transfers these activities from State Department of Public Welfare to the new department; leaves in State Department of Public Welfare activties and programs relating to public assistance. Measure as passed vetoed by Governor; veto over-ridden. Effective July 1, 1954.

S. B. 271, permits special public health levies to cover a period of five years, instead of one year. Became effective June 30. (See H. B. 77, also.)

S. B. 292, requires Blue Cross Hospital plans to submit proposed rate changes to the Superintendent of Insurance for his approval, prior to becoming effective. Effective Oct. 16.

S. B. 342, permits a board, bureau or commission to appeal from an adverse decision of the Common Pleas Court; amends a loophole of the Administrative Procedure Act cited in a recent State Supreme Court decision. Effective Oct. 21.

H. B. 1, revision of the entire General Code as to format, wording, arrangement, deletion of obsolete provisions, etc.; no changes in substance. Effective Oct. 1.

H. B. 10, General Appropriations Act; provides for state appropriation of approximately $2,637,-558 to Ohio Department of Health for the biennium 1954-55 which is an increase of approximately $885,000 over the last biennium, exclusive of state subsidies to local health departments. For the first time in years, the state is appropriating more for the department than the department anticipates receiving from the Federal Government in the form of grants-in-aid. Effective July 8.

H. B. 48, requires hog feeders to cook garbage used for feeding. Effective Oct. 2.

H. B. 77, permits special public health levies to cover a period of five years, instead of one year. Same as S. B. 271, except that S. B. 271 covers the period June 30 to Oct. 1 and H. B. 77 becomes effective Oct. 2 under the Revised Code.

H. B. 87, relative to recording of birth records of adopted children. Effective Oct. 2.

H. B. 94 and H. B. 190, to increase the salaries of appointive state officials; provides for annual salary of $12,000.00 for State Director of Health but will not apply to incumbent director whose term began prior to passage of the act. Effective July 13 and Oct. 2, respectively.

H. B. 105, relative to Workmen's Compensation; principal Workmen's Compensation bill enacted during the session. Under this bill employers will be assessed in amounts sufficient in the aggregate to repay to the State General Revenue Fund two-thirds of the $6,205,164 which has been appropriated for the costs of administration of the Industrial Commission for the biennium July 1, 1953, to and including June 30, 1955. It is

declared in the bill that one-third of the administrative costs of the Industrial Commission should be paid from the General Revenue Fund and the bill contains the provision that collections from employers "shall be, but not exceed, two-thirds of the sum appropriated by the General Assembly."

Also, the bill provides for paying a minimum of $25.00 a week to workmen who are permanently and totally disabled, thus raising such compensation to such claimants awarded compensation in a lesser amount in previous years. This increase is appropriated from the state's General Revenue Fund. Effective October 21.

H. B. 130, authorizes a municipal corporation to lease a general hospital which it owns to a nonprofit charitable nonsectarian corporation for maintenance and operation as a general hospital. Effective Oct. 2.

H. B. 142, gives superintendents of state hospitals and probate courts greater discretion regarding admission to such institutions and regarding the discharge from the institutions of persons who are not mentally incompetent but who are disabled because of age, chronic disease, etc. Effective Oct. 2.

H. B. 256, places reasonable restrictions on the state licensing boards, including the State Medical Board, and provides a way a person aggrieved by action of any board may secure a hearing from an appeal board. Effective Oct. 19.

The Senate voted down S. B. 227, to create a new department to license occupations and professions. The Association opposed that bill. Then, a new bill, S. B. 323, was introduced. It would have subjected the boards to the veto of a so-called board of review and would not have permitted appeal to the courts. The Association opposed that measure, also. However, it was reported out and recommended for passage by the Senate Judiciary Committee.

While all this was taking place in the Senate the House passed Sub. H. B.256, which was a compromise measure, incorporating certain provisions of three House bills affecting licensing boards. The Association supported H. B. 256.

Sub. H. B. 256 was heard by the Senate Judiciary Committee. Prior to the committee session, conferences were held by O. S. M. A. representatives and representatives of other professions and occupations with Senator Sheppard, Akron, author of S. B. 227 and S. B. 323 and chairman of the Senate Judiciary Committee and other members of the Assembly interested in this kind of legislation.

The result of this conference was the drafting of an agreed amendment to Sub. H. B. 256, strengthening that measure but discarding the drastic provisions of S. B. 323. Senator Sheppard presented the amendment at the committee hearing. The committee adopted the amendment and reported out and recommended Sub. H. B. 256, as amended, for passage.

H. B. 256, as amended, was subsequently enacted and signed by the Governor. Here are its provisions:

1. Requires that appointments made by the governor to all licensing boards or agencies must be confirmed by the Senate.

2. Requires that the examination papers written by all applicants shall be open to inspection by an applicant or his attorney for a period of ninety days after the examination.

3. Requires each board to file a semi-annual report of its activities with the newly-created legislative service commission which shall consolidate the reports and transmit the composite report to members of the General Assembly so they will be familiar with the work of the boards.

4. Establishes a board of review, composed of the secretary of state, auditor of state and treasurer of state. A person aggrieved by an act of a licensing board or agency may file a complaint with the board of review. It may investigate any complaint which it deems valid. If an investigation is made, a board affected may demand a hearing. The hearing must be conducted in conformity with the administrative practices act. If the board of review finds the act of the board unreasonable or unlawful, it may order the board to rescind the action.

5. Provision is made that any action of the board of review may be appealed to the common pleas court by either the board or the complaining party.

6. Requires the board of review to report the results of investigations made by it to the General Assembly.

(At the last meeting of the Senate Judiciary Committee on this measure, Senator Sheppard, chairman of the committee and the author of two other bills on this subject, both of whom had been vigorously opposed by representatives of the O. S. M. A., publicly congratulated representatives of the O. S. M. A. and of other interested groups for their help and constructive attitude in working out the compromise bill. Other members of the committee, and many members of the General Assembly, who were vitally interested in some kind of legislation to place some restrictions on the state boards, expressed similar sentiments.)

H. B. 258, provides for service of process on non-resident employers and resident employers of this state who become non-resident or cannot be located and are amenable to the Workmen's Compensation Act. Service would be made by serving the Secretary of State and mailing by registered mail a copy of the summons to the party's last known address. Effective Oct. 13.

H. B. 355, gives a county hospital board authority to have its own bank account, known as the

hospital operating fund, in a private financial institution, instead of having to deposit and disburse all funds through the county auditor and county treasurer. Effective Oct. 13.

H. B. 401, creates a State Bureau of Vocational Rehabilitation under the State Board of Vocational Education and assigns to it certain activities and duties with regard to the vocational rehabilitation of certain disabled persons. Effective Oct. 26.

H. B. 429, provides that restaurants shall be licensed and inspected with regard to health and sanitary conditions by public health departments instead of by the State Fire Marshall. Effective Oct. 29.

H. B. 438, writes into the Retail Sales and Use Tax Laws the meaning of Sales Tax Regulation 102 of long-standing which applies to physicians and dentists. The State Dental Society sponsored the bill, believing it was necessary to clarify a pending court case in which it was contended that dentists should collect a sales tax from patients on dentures made for the dentist by a dental laboratory. Effective Oct. 13.

This law in effect provides (1) physicians and dentists must pay the retail sales or use tax on tangible personal property used by them in their practice; (2) do NOT have to collect a sales or use tax from patients on fees charged for professional services or on articles and medicines dispensed to patients as an incidental part of their professional services and for which no separate charge is made; (3) WILL be required to secure a tax vendors license and to collect the retail sales tax from patients if they engage in the selling of medical supplies, eye glasses, dentifrices, and such articles to patients and make a separate charge for such tangible articles. The law does not in any way change the present procedure as it applies to physicians and dentists, merely writes into the law the meaning of the Tax Department's regulation.

H. B. 440, requires all boards and commissions, except pardon and parole board, to hold public meetings when final decision on pending matters is made. Effective Jan. 31, 1954.

H. B. 491, deletes the $10.00 per diem ceiling on payments to hospitals by the Bureau of Motor Vehicles for the care of indigents injured in motor vehicle accidents and substitutes in its place a formula which states that the rate certified shall not exceed a sum equal to the weighted average per diem cost of the 25 highest cost hospitals in the state; also provides that state will not be obligated to pay during the time that hospital costs are being made under an insurance plan or by relatives of the patient.

H. B. 494, authorizes executive secretary of county child welfare board to give consent to medical, dental and surgical care on behalf of a ward. Effective Oct. 2.

H. B. 576, amends the privileged communications law to permit an attorney or physician to testify in litigation after his client or patient has died providing consent is given by the surviving spouse or the executor or administrator. Effective Oct. 13.

H. B. 658, authorizes special school classes for persons with tuberculosis. Effective Oct. 2.

H. B. 665 and H. B. 666, one applying to the old code and the other to the Revised Code, providing that the State Department of Health shall have the power to adopt reasonable rules and regulations to establish and maintain minimum standards for voluntary and government hospitals in Ohio. Deemed necessary to meet certain provisions of Federal rulings applying to grants-in-aid for public assistance programs. Effective August 12 and Oct. 2, respectively.

H. B. 781, gives the State Medical Board the right, at its discretion, to admit graduates of foreign medical schools to the state board examinations in cases where the applicant does not have a license to practice in a foreign country—a requirement of the old law—providing the applicant has taken at least one year of intern or resident training in an approved hospital in the United States. Effective Oct. 26.

Officials of the board and State Association cooperated with members of the Legislature in drafting this measure. It was deemed necessary to meet some difficult problems which have arisen in connection with the licensing of certain foreign physicians who are well-qualified from the standpoint of education but cannot meet the legal requirements of the old law as to holding a license in a foreign country, because of citizenship requirements in the foreign country or because of post-war chaos. The new law is sound in that it leaves the board in complete control of the situation and empowers it to exercise discretion in individual cases.

H. B. 814, increases monthly awards to recipients of Aid for the Aged from $60 to $65. Effective Oct. 26.

H. B. 816, the so-called Additions and Betterments Bill, providing for capital improvements at state institutions, parks, etc. One provision appropriates $1,150,000 for the erection by the state of a tuberculosis hospital in Southeastern Ohio. Another provision authorized $500,000 for additional classrooms at the Ohio State University College of Medicine. Became effective July 30.

BILLS NOT PASSED BY ASSEMBLY

Among measures, having a medical or health angle, which were **not passed** by the General Assembly, were the following bills:

To create a separate examining and licensing board for chiropractors; also to create a board to examine and license naturopaths. Both meas-

(Continued on Page 854)

Fall Postgraduate Courses . . .

A Number of District and Regional Meetings Scheduled Throughout The State Offer Ohio Physicians an Excellent Choice of Programs

AN excellent array of postgraduate courses is being offered to Ohio physicians this fall in various sections of the State. Many of them are annual events and are well known to physicians in the area. The programs show an excellent choice of subject matter and list speakers of reputation in the profession.

Additional information on these and other programs will be published in subsequent issues of *The Journal.* Following are the programs announced before this issue went to press:

September 16-17—Ohio Academy of General Practice, Cleveland.

September 25-26—Course in pulmonary diseases, Ohio State University College of Medicine, Columbus.

October 2—Second Councilor District Meeting, Dayton.

October 14—Northwestern Ohio Medical Association, Toledo.

October 28—Sixth Councilor District Meeting, Canton.

November 5-7—Saint Luke's Hospital Symposium, Cleveland.

November 11—Ohio and Western Pennsylvania Regional Meeting, American Rheumatism Association, Akron.

December 3—Cancer Symposium, Youngstown.

* * *

Second District Meeting To Be Held In Dayton, October 2

The Second Councilor District Medical Society will hold its fall meeting this year in the Biltmore Hotel, Dayton, on Friday, October 2, with a meeting also of the District Woman's Auxiliary.

Preceding the program a luncheon will be given for component County Society presidents and secretaries. Details of the afternoon scientific program will be announced later. The program committee, as this issue went to press, was working on an excellent program and assured physicians of top rank talent as speakers. Discussion periods and a business meeting also are planned.

Highlight of the evening banquet will be a talk by Dr. Edward J. McCormick, Toledo, President of the American Medical Association. Also featured for the evening meeting will be selections by the Doctors' Orchestra of the Montgomery County Medical Society.

Joining forces with the District meeting will be the annual celebration of Founders' Day for the Montgomery County Medical Society. This will be the 104th event for the Society.

Host for the evening meeting will be Dr. Robert Austin, president of the Montgomery County Medical Society.

Presiding at meeting of the District will be Dr. C. J. Brian, of Eaton, District president, and working with many of the details will be District Secretary Frank Anzinger, of Springfield.

The program committee for the District consists of Dr. T. L. Light, Dayton, chairman; Dr. M. M. Cain, Greenville, and Dr. L. T. Sontag, Yellow Springs.

* * *

Northwestern Ohio Association Schedules Program Oct. 14

The Northwestern Ohio Medical Association, comprising the Third and Fourth Councilor Districts, has announced features of its program for its 109th meeting to be held this year at the headquarters of the Toledo Academy of Medicine, 3101 Collingwood Ave., Toledo, on Wednesday, October 14. All physicians in good standing with their local societies are invited. The tentative program is as follows:

9:30 - 10:00 a. m.—Registration, and business meeting presided over by Dr. George H. Lemon, Perrysburg, President of the organization; address of welcome by Dr. Wendell W. Green, president, Toledo and Lucas County Academy of Medicine.

10:05 - 10:45—Dr. H. Keith Fischer, Department of Psychiatry, Temple University School of Medicine, Philadelphia, "Psychiatry and the Physician's Responsibility in Teen Age Development and in the Problems of Young Adults."

10:50 - 11:30—Dr. Charles P. Bailey, professor of Thoracic Surgery, Hahnemann Medical College and Hospital, Philadelphia, "Recent Advances in Cardiac Surgery."

11:35 - 12:15—Dr. Ernest M. Brown, Jr., Department of Medicine, University of Pennsylvania Medical School, Philadelphia, "Uses and Abuses of ACTH and Cortisone Therapy."

12:20 - 1:30—Recess for luncheon; informal round table conferences with guest speakers; social period.

1:35 - 2:30 p. m.—Post Luncheon Session and Election of Officers.

Mr. Charles S. Nelson, Columbus, Executive

Secretary of the O. S. M. A., "News from the Ohio State Medical Association Headquarters."

Reports by the following:

Dr. James R. Jarvis, Van Wert, Councilor of the Third District.

Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District.

2:35 - 3:15—Dr. Craig W. Muckle, Department of Gynecology and Obstetrics, Pennsylvania and Lying-In Hospital, Philadelphia, "Ovarian Cancer."

3:20 - 4:00—Dr. William Clatworthy, Department of Surgery, Ohio State University College of Medicine, Columbus, "Advances in Pediatric Surgery."

* * *

General Practitioners To Meet in Cleveland, September 16-17

The Third Annual Scientific Assembly of the Ohio Academy of General Practice will be held on Wednesday and Thursday, September 16 and 17, at the Hotel Cleveland, Cleveland. The following program has been announced:

WEDNESDAY, SEPT. 16
(Daylight Savings Time)

1:20- 1:50—"The Low Back Syndrome," Wallace S. Duncan, M. D., Cleveland, associate surgeon, Department of Orthopedic Surgery, St. Luke's Hospital; chief, Department of Orthopedic Surgery at Woman's Hospital, and at Doctor's Hospital; consultant in Orthopedic Surgery at the Glenville Hospital and the U. S. Marine Hospital.

1:55- 2:25—"Treatment of Hypertension," Irvine H. Page, M. D., Cleveland Clinic.

2:30- 3:00—"Time Honored Medical Procedures," C. Lee Graber, M. D., Cleveland, chief of staff and chief of surgery, Lakewood Hospital.

3:05- 3:35—"Diagnosis of Cancer of the Uterus," Robert L. Faulkner, M. D., associate professor of obstetrics and gynecology, Western Reserve University School of Medicine.

3:40- 4:10—"Importance of Treating Peptic Ulcer with Unlimited Diet," Edward A. Marshall, M. D., Cleveland, chief of Department of Huron Road Hospital.

4:15- 5:00—"Indications for Gastric Surgery," Richard R. Renner, M. D., chief of surgery, Doctors Hospital, and director of surgery, Doctors Clinic, Cleveland.

THURSDAY, SEPT. 17
(Daylight Savings Time)

9:00- 9:30—"Use and Abuse of Physical Medicine in General Practice," Harry T. Zankel, M. D., Cleveland, chief, physicial medicine rehabilitation, Crile V. A. Hospital.

9:35-10:05—"Some Recent Advances in Pediatrics," James G. Kramer, M. D., Akron, pediatrician to Akron Children's Hospital, Akron City Hospital, and Summit County Children's Home.

10:10-10:40—"A Newspaperman Views the Medical Profession," Mr. Don Dunham, Cleveland, medical writer for *The Cleveland Press.*

10:40-11:00—Recess.

11:05-11:35—"Pregnancy Accidents Associated with Alterations in the Hemostatic Mechanism," Duncan E. Reid, M. D., Boston, professor of obstetrics, Harvard Medical School, obstetrician-in-chief, Boston Lying-in Hospital.

11:40-12:10—"Spontaneous Hypoglycemia. Differential Diagnosis and Management," Jerome W. Conn, M. D., Ann Arbor, Mich., professor of internal medicine and director of endocrinology and metabolism, the Metabolic Research Laboratory, University of Michigan Medical School, Ann Arbor.

SPECIAL EVENTS

The Banquet will be held in the Grand Ballroom, Hotel Cleveland, on Wednesday, September 16, beginning at 7:00 p. m., with Dr. George W. Crile, Jr., as Banquet speaker. He will present an illustrated and entertaining talk and movie on "Treasure Hunting Holiday." Music, floor show and dancing will complete the evening until 1:00 a. m.

Entertainment has been arranged for the ladies for Wednesday as guests of the O. A. G. P. for noon luncheon, 12:30-2:30 at Higbee Company, Silver Grill, to be followed by a style show.

The House of Delegates of the Ohio Academy of General Practice will convene at 10:00 a. m., Tuesday, September 15, at Hotel Cleveland.

* * *

Sixth District Program Scheduled In Canton, October 28

The Sixth Councilor District annual Postgraduate Day will be held on Wednesday, October 28, at the St. Francis Hotel, Canton.

Full details of the program will be printed later. As this issue of *The Journal* was going to press, the following features and speakers had been announced:

Panel Discussion Topics:

1. "Infectious Diseases of the Pancreas and Chronic Relapsing Pancreatitis."

2. "Chronic Ulcerative Colitis and Regional Enteritis."

Panel members will include: Dr. Robert M. Zollinger, chief of the Department of Surgery, Ohio State University College of Medicine, moderator; Dr. Sara Jordan and Dr. Kenneth W. Warren, Lahey Clinic, Boston; Dr. Philip F. Partington, Western Reserve University School

of Medicine; Dr. Everett N. Collins and Dr. J. Beach Hazard, Cleveland Clinic.

Papers will be presented by Dr. Jordan, Dr. Hazard, Dr. Partington and Dr. Warren.

Dr. Richard H. Overholt, Tufts College Medical School, will speak during the evening program on the subject, "The Fourth Dimension in Thoracic Surgery."

Reservations may be made through Mr. E. M. Sprunger, executive secretary, the Stark County Medical Society, 400 Fourth St., N. W., Canton 2.

* * *

Cancer Symposium To Be Held In Youngstown

Again this year the Mahoning County Medical Society in cooperation with the Mahoning County Chapter of the American Cancer Society will sponsor a Cancer Symposium in Youngstown. The date has been set for Thursday, December 3.

An outstanding national cancer team has been invited to conduct the programs. Dr. A. J. Brandt, chairman of the County Society Cancer Committee, and Dr. Stephen W. Ondash, Society program chairman, are working jointly on arrangements.

Details will be announced in a forthcoming issue of *The Journal.*

* * *

American Rheumatism Association To Present Program in Akron

The Ohio and Western Pennsylvania Regional Meeting of the American Rheumatism Association will be held in the Mayflower Hotel, Akron, on Wednesday, November 11. Physicians of Ohio, Western Pennsylvania and Southeastern Michigan are invited, especially general practitioners. Acting regional chairman is Dr. Roger Q. Davis, 1405 Goodyear Blvd., Akron 5.

A registration fee of $5 has been announced with dinner tickets at $5 each. Exact subjects in the field of rheumatic diseases will be announced later. The list of speakers and the time at which they will speak has been announced as follows:

9:20 a. m.—Dr. Robert M. Stecher, chief of the Arthritis Clinic Cleveland City Hospital; past-president of the American Rheumatism Association; president of the International Rheumatism Association.

9:30—Dr. Currier McEwen, dean of the University of New York Medical School; past-president of the American Rheumatism Association.

10:10—Dr. Charles Ragan, associate professor of medicine, Columbia University College of Physicians and Surgeons; president, the American Rheumatism Association.

11:00—Dr. Richard H. Freyberg, associate clinical professor (medicine), University of New York Medical School.

11:40—Dr. Robert L. Preston, assistant clinical professor of orthopedic surgery, New York University Post Graduate Medical School.

1:20 p. m.—Dr. John H. Talbott, professor of medicine, University of Buffalo College of Medicine.

2:00—Dr. Gordon M. Martin, consultant in physical medicine and rehabilitation, Mayo Clinic; assistant professor of physical medicine and rehabilitation, University of Minnesota Medical School.

2:50—Dr. Joseph J. Bunim, chief, Arthritis and Rheumatism Branch, National Institutes of Arthritis and Metabolic Diseases, Bethesda, Md.; associate professor of medicine, Johns Hopkins University.

3:40—Panel—Questions and Answers.

7:00 p. m.—Dinner (speaker to be announced).

* * *

Saint Luke's Hospital Symposium Scheduled Nov. 5-7

"Surgical Care of the Injured Hand," will be the theme of the three-day Fall symposium at Saint Luke's Hospital, Cleveland, Thursday, Friday and Saturday, November 5, 6 and 7.

The program has been announced as follows:

NOV. 5—MORNING SESSION

8:00 - 9:00 a. m.—Registration.

"Form and Function"

Dr. W. H. McGaw, St. Luke's Hospital, chairman; Dr. Darrel T. Shaw, St. Luke's, co-chairman.

9:00 - 9:15—"Finger Tip Injuries," Dr. Robert Holmberg, St. Luke's.

9:15 - 9:45—"Functional Anatomy Film," Dr. Donald Eyler, Nashville, Tenn.

9:45 - 10:15—"The Wrist, The Carpal Bones and Their Injuries," Dr. Wallace S. Duncan, St. Luke's.

10:15 - 10:45—"Emergency Treatment of Burns," Dr. Carl A. Hamann, Cleveland; discussion by Dr. Clifford L. Kiehn, Cleveland.

10:45 - 11:15—"The Anatomical Peculiarities of the Hand," Dr. Normand L. Hoerr, Cleveland.

11:15 - 11:45—Discussion and Break.

11:45 - 12:00—Invocation by the Rev. Harry A. Hull; welcoming address by Mr. Theodore Thoburn; introduction of committee heads; introduction of Mrs. Marion Hall and Mr. Kenneth Shoos.

12:15 - 2:00 p. m.—Luncheon, Nurses' Residence, East Wing.

NOV. 5—AFTERNOON SESSION

"Injury"

Dr. Donald M. Glover, Cleveland, chairman; Dr. Vinton E. Siler, Cincinnati, co-chairman.

2:00 - 2:30—"Hand Injuries in Industry," Dr. Don A. Kelly, Cleveland.

(Continued on following page)

2:30 - 3:00—"Farm Hand Injuries," Dr. Harvey Allen, Chicago.

3:00 - 3:30—"Injuries About the Home, Garden, Garage and Cellar," Dr. William F. Kubicek, St. Luke's.

3:30 - 4:00—"Emergency Treatment and Accident Room," Dr. Kent L. Brown, St. Luke's.

4:00 - 4:30—"The Operating Room Care," Dr. Philip F. Partington, Cleveland.

4:30 - 5:00—Discussion.

NOV. 5—EVENING SESSION

"The Injured Hand"

6:00 - 8:00 p. m.—Dinner, East Wing.

Dr. Donald M. Glover, Cleveland, chairman; Dr. William D. Holden, Cleveland, co-chairman.

Dr. Rollett A. Carson Memorial Lecture, Dr. Harvey Allen, Chicago.

Speakers' Table: Drs. Harvey Allen, Donald M. Glover, Vinton E. Siler, Donald Eyler, Darrel T. Shaw, William D. Holden, W. H. McGaw and Stephen S. Hudack.

NOV. 6—MORNING SESSION

"General Techniques"

Dr. Harvey Allen, Chicago, chairman; Dr. William Downing, St. Luke's, co-chairman.

9:00 - 9:30 a. m.—Planning the Problem," (the Case, Conservation, Flaps)," Dr. Darrel T. Shaw, St. Luke's.

9:30 - 9:45—"Anesthesia, Block, Regional," Dr. B. B. Sankey, St. Luke's.

9:45 - 10:00—Markee Film, "Functional Anatomy," Dr. Donald Eyler, Nashville, Tenn.

10:00 - 10:20—"Injury to the Bones and Joints of the Hands," Dr. W. H. McGaw, St. Luke's.

10:20 - 11:10—"Injury to the Tendons," Dr. P. J. Robechek, St. Luke's.

11:10 - 11:40—"Injury to the Nerves," Dr. Frank E. Nulsen, Philadelphia, Pa.

11:40 - 12:10—"Injury to the Soft Parts," Dr. Clifford L. Kiehn, Cleveland.

12:10 - 12:30—Discussion.

12:30 - 2:00 p. m.——Luncheon, East Wing.

NOV. 6—AFTERNOON SESSION

"Restitution"

Dr. Darrel T. Shaw, St. Luke's, chairman; Dr. Carl A. Hamann, Cleveland, co-chairman.

2:00 - 2:30 p. m.—"Scars, Splints and Exercise," Dr. Elden C. Weckesser, Cleveland.

2:30 - 3:00—"Tendon Transfer," Dr. George S. Phalen, Cleveland.

3:00 - 3:30—"Tendon Graft," Dr. Sam G. Stubbins, St. Luke's.

3:30 - 4:00—"Tendon Replacement," Dr. Stephen S. Hudack, St. Luke's.

4:00 - 5:00—"Plastic Reconstruction," Round Robin (incisions, scars, Z-plasties, keloid contractures, flaps and grafts), Drs. Donald M. Glover, Clifford L. Kiehn, Darrel T. Shaw, Harvey Allen, Vinton E. Siler and Carl A. Hamann; all of Cleveland.

NOV. 6—EVENING SESSION

"Pain"

Dr. Frank E. Nulsen, Philadelphia, chairman; Dr. W. James Gardner, Cleveland, co-chairman.

8:00 - 10:30 p. m.—Round Robin:

"Dystrophy," Dr. William D. Holden, Cleveland

"Pain, Body Image and Mutilation," Dr. William A. Nosik, St. Luke's.

"Spine, Cord and Brachial Plexus," Dr. Spencer Braden, St. Luke's.

"Causalgia," Dr. Vinton E. Siler, Cincinnati

Discussion, Dr. Reynold M. Crane, St. Luke's.

NOV. 7—MORNING SESSION

"Special Interest"

Dr. Vinton E. Siler, Cincinnati, chairman; Dr. Donald Eyler, Nashville, co-chairman.

9:00 - 9:30 a. m.—"Acute Inflammation," Dr. William Downing, St. Luke's.

9:30 - 10:00—"Tumors of the Hand," Dr. Walter A. Engel, St. Luke's.

10:00 - 10:30—"Radiation Injury," Dr. Donald M. Glover, Cleveland.

10:30 - 11:00—"Burns—Plastic Reconstruction," Dr. Clifford L. Kiehn, Cleveland; discussion by Dr. Carl A. Hamann, Cleveland.

11:00 - 11:30—"Vessels, Nerves, Nails and Skin in Diagnosis," Dr. Herbert H. Johnson, St. Luke's.

11:30 - 12:00—"Congenital Malformations," Dr. Joseph E. Brown, St. Luke's.

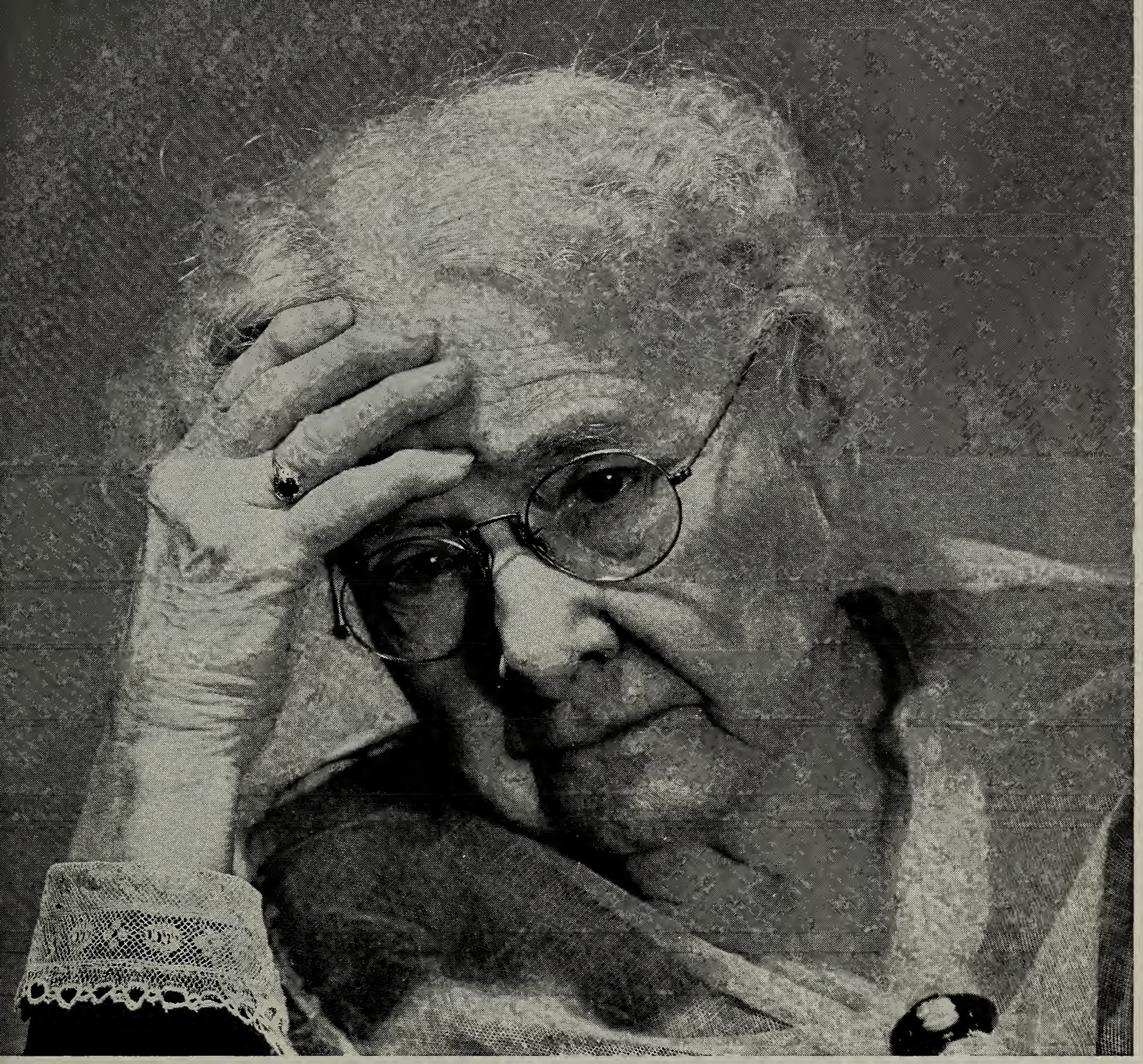
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Excellent Course in Pulmonary Diseases, September 25-26

A postgraduate course in pulmonary diseases, planned especially for general practitioners, will be given September 25 and 26 at the Ohio State University College of Medicine and the Neil House, Columbus. General practitioners attending will be given nine hours credit by the Ohio Academy of General Practice. The course is being sponsored by the College of Medicine, the Ohio Trudeau Society, Ohio Tuberculosis and Health Association and the Ohio State Medical Association.

The registration fee for the course is $15.00. Course reservations must be made in advance to Mr. H. G. Howson, treasurer, Ohio Tuberculosis Hospital, Ohio State University, Columbus. Hotel reservations should be made direct with the hotel of choice. All sessions will be at the College of Medicine, except the Friday night session which will be at the Neil House.

A complete program for the course was mailed to all members with the June issue of the *OSMAgram* and was published in the June issue of the *Ohio State Medical Journal.* Reference to the course also was made in the August issue.



The inevitable restrictions of advancing years, the reduced activity and a lowered intake of bulk-producing foods all contribute to the high incidence of constipation in older persons.

CONSTIPATION IN THE AGED

Constipation is almost a universal complaint of geriatric patients

Frequently, too, the protracted use of cathartics has left the colon in an atonic state and it is no longer capable of effecting a normal evacuation.

Metamucil has long been recommended for the treatment of constipation in the elderly. A highly refined vegetable product which is free from irritants, Metamucil effects a natural mechanical stimulus in the colon which helps the dysfunctioning muscles to regain and maintain their normal tone.

Metamucil may be safely prescribed for prolonged use without fear of dependence, intestinal irritations or allergic reactions.

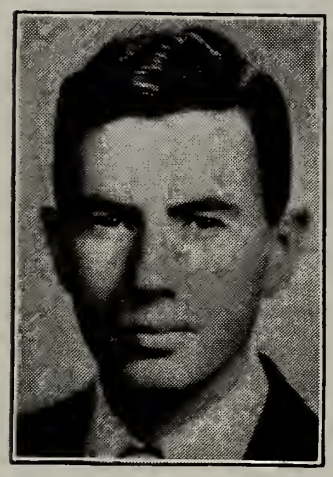
Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

Rural Medical Scholarship . . .

Fifth Recipient of State Association's Award To Enter Medical School In Fall; One Now Through School, Others Are Undergoing Training

THE winner of the fifth annual Ohio State Medical Association Rural Medical Scholarship, which will contribute $2,000 toward his medical education, is Raymond M. Cole, Findlay, who for 19 years lived on a farm near Mt. Blanchard, Hancock County.



R. M. COLE

Cole, who is married and the father of one child, received his premedical training at Bowling Green State University and the Ohio State University. He will enter the University of Cincinnati College of Medicine this Fall.

While on the farm he engaged in 4-H Club and Future Farmers of America activities. He served as secretary to the Methodist Church and president of the Church Young Peoples' Society.

The scholarship plan was instituted four years ago by the Ohio State Medical Association to stimulate the interest of rural young men and women in the study of medicine in order that Ohio's supply of country doctors might be further increased.

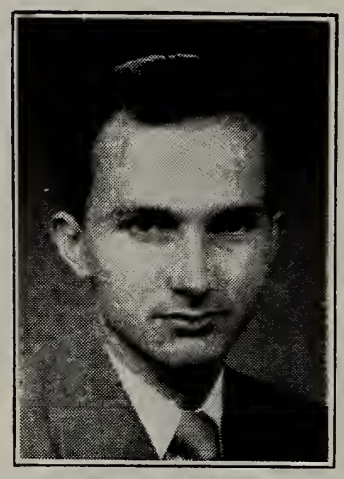
Administered by the Association's Committee on Rural Health, a group made up largely of rural physicians engaged in the general practice of medicine, the award is given each year. Selections are made by a sub-committee of the O. S. M. A. Committee on Rural Health, from applicants who have finished their premedical training and have been accepted by a school of medicine in the United States.

The winner receives $500 for each of his four years in medical school. The plan continuously aids four medical students, one in each of the four classes.

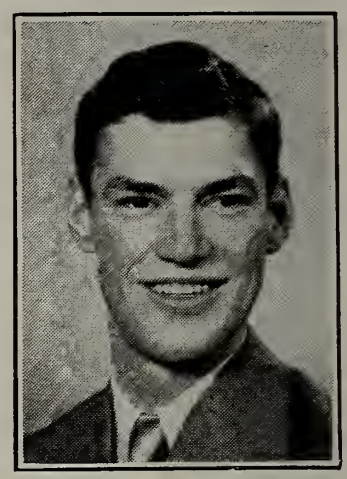
WRIGHT NOW INTERNING

The first recipient of the scholarship, Dr. C. Craig Wright, formerly of Winterset, Guernsey County, is now taking his internship at the Bellevue Hospital in New York City. Dr. Wright appeared before the House of Delegates of the Ohio State Medical Association in April to thank the organization for the award, and to report on his medical school activities.

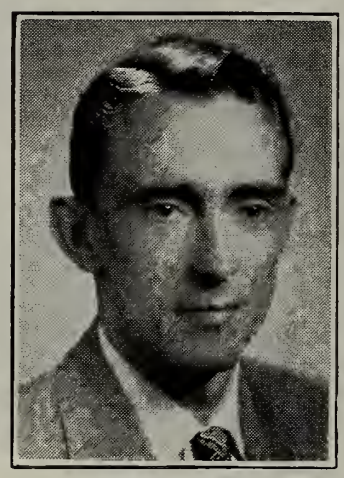
Robert G. Smith, from Proctorville, Lawrence County, married and the father of four children, was the second winner of the award. He is a



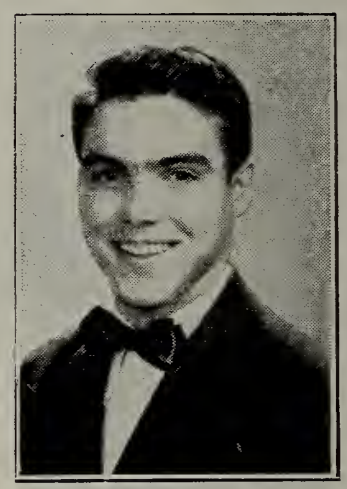
J. D. TIMMONS



DONALD NIKOLAUS



R. G. SMITH



C. C. WRIGHT, M. D.

senior at the Ohio State University College of Medicine.

A combat veteran of World War II, Smith completed his premedical work at Ohio State and graduated cum laude. His background is one of outstanding achievement in farm and youth groups while living on the farm.

The third winner of the scholarship, Donald Nikolaus, of Johnsville, Morrow County, is a junior at the Ohio State University College of Medicine this fall. During the summer quarter he was employed as an extern at the Lodi Hospital at Lodi, Ohio.

He received his college training at Ashland College and graduated as valedictorian and president of the class. He is married and his wife teaches school in Columbus.

J. Daniel Timmons, of New Madison, who received last year's award, is a sophomore at the Ohio State University College of Medicine. He received his premedical education at Manchester College, North Manchester, Indiana. He was valedictorian of his graduating class and active in many college activities.

NOW! Not for 26 weeks — Not for 52 weeks BUT—

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from the FIRST DAY** of sickness or injury

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ADDRESS.....

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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

TEAMWORK ON LEGISLATION PAYS DIVIDENDS

It is hoped that all readers will at least scan the article in this issue entitled "Legislative Review" which summarizes action of the 100th Ohio General Assembly on medical-health measures and other proposals of special interest to physicians. Little more needs to be said regarding the work of the General Assembly itself.

However, there is one point in connection with the recent legislative session which is worthy of comment, namely: **There was much tangible evidence of the importance of and need for coordinated activity on the part of all groups interested in public health legislation and what can be accomplished by pulling together.** For example:

Through the combined efforts of representatives of the medical, dental, nursing, pharmaceutical, optometrical, and veterinary medical professions, and representatives of other professions and trades, proposals which would have seriously interfered with the activities of the state licensing boards and, in the end, adversely affected the public's interest, were defeated. There was real team-play.

The medical and dental professions' representatives worked together on a bill revising a section of the Sales Tax Law of special importance to physicians and dentists.

There was real teamwork on the part of the medical and allied professions, official and non-official public health groups, and lay organizations in giving strong support to measures providing for more adequate financing of the state and local public health departments and other measures which will enable the public health agencies to do a better job.

The very closest of cooperation between the medical and pharmacy professions was established in presenting information and advice to the General Assembly on drug and narcotic proposals; also on many other bills of mutual interest.

Close liaison was established by the medical profession with officials of the State Department of Health on pending measures affecting official public health activities in Ohio.

Representatives of major welfare organizations and representatives of the medical profession coordinated their efforts in support of some of the constructive welfare bills which were enacted.

Frequent conferences were held between representatives of the medical profession and hospital officials on questions of mutual interest.

These examples show that much can be done in the interests of public health if all groups directly interested will, first, agree on basic principles, and, second, roll up their sleeves and go to work.

The medical profession had to fight single-handedly, for the most part, against efforts of certain limited practitioners to tear down the Medical Practice Act. The fight was successful but, in the future, the medical profession has a right to expect the support of all other groups interested in maintaining health standards in battles to defeat such proposals which, in the end, are a menace to public health and would lower health and medical standards in Ohio.

Obviously, the final action for or against the measures supported or opposed by these groups had to be taken by the General Assembly. For that reason it would be unfair not to get in here a word of appreciation and thanks to those members of the General Assembly who listened patiently to the arguments which were presented pro and con and then acted as their judgment dictated—in line with the views expressed by the groups which have been enumerated in most instances.

MEDICINE LOSES TWO DISTINGUISHED CHAMPIONS

"It is ironical that Dr. Elmer L. Henderson and Senator Robert A. Taft, two close friends who boldly and aggressively championed the cause of freedom in medical practice—and freedom for all Americans—should suffer the same fatal disease and died within 24 hours of each other. The two distinguished men delivered many speeches that sounded the battle cry of freedom in both medicine and government."

The above is an excerpt from an "In Memoriam" statement issued by the American Medical Association, the balance of which quoted from historic addresses made by Dr. Henderson and Senator Taft.

Amplification of the quotation hardly seems necessary. Both men were so well known in their chosen callings that words of tribute are somewhat anti-climatic. However, it must be noted that in their passing, the medical profession has suffered the loss of two outstanding champions for the causes and principles to which the great majority of physicians subscribe.

With respect to Dr. Henderson it can be said that probably no physician has given as much time and energy to the fundamental struggle against state socialism as he did while serving



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the American Medical Association as a trustee, president and head of a special committee on public education and legislation.

The death of Senator Taft marks the passing of one of the nation's all-time distinguished statesmen, whose constant battle to preserve fundamental American doctrines won him nation-wide acclaim. It constitutes a great personal loss for the thousands of Ohio physicians who knew him as a friend and, realizing that men of his stature were needed in public office, eagerly and actively supported him when his political fate rested with the voters.

The nation as a whole benefited enormously from the courageous and untiring efforts of these two, especially during the recent dangerous years. Although bereaved at their passing, the medical profession is proud to be able to claim one of them as a member of its ranks and gains much satisfaction from the fact that it took a prominent part in making it possible for the nation to reap the benefits which accrued from the great services rendered by Ohio's distinguished son.

TO BE OR NOT TO BE—CONSISTENT

President Eisenhower undoubtedly is finding out what other politicians have discovered, namely: It is difficult to mix consistency and politics.

On August 1, the President recommended to Congress a plan to add some 10 million self-employed persons, including physicians, to the Social Security rolls.

On the same day, he warned a group of White House visitors that "as government gets larger and more powerful it becomes necessary to look at it with a cold and fishy eye," concluding with the admonition: "Don't let it(government) get deeper into our lives."

The A. M. A. House of Delegates is on record (1949) against inclusion of physicians in the Social Security program, believing the building up of a retirement insurance program is a right which should be reserved for the individual. It has been supporting proposed legislation (Jenkins-Keogh Bills) to permit physicians and other self-employed to make deductions from income tax returns of part of the premiums paid for such insurance. Prior to last Fall's election, the President expressed approval of the principle of such legislation. Hearings are being held on the measures but the mills are grinding very slowly.

Just what is the policy of the administration on this issue?

It's time we were finding out.

Even should physicians be included in the Social Security plan eventually, that is no reason why they should be denied an opportunity to defer tax payments on premiums set aside for retirement insurance—a privilege now enjoyed by employees of industries and organizations having voluntary retirement insurance programs.

HOW ABOUT A CHAT WITH YOUR CONGRESSMAN?

Now is a good time to renew acquaintance with your Congressman. As the Washington Letter of the A. M. A. Washington Office points out:

"With the nation's lawmakers home or on their way home, this is a timely week to suggest that you look them up. Let them know not only how you feel about medical legislation, but why. If they have been helpful to us, you will do the Washington staff a great service by thanking them for their support. Some of the Senators and Representatives may not agree with you, but it's a rare one who doesn't welcome the opinion of a doctor who knows what he's talking about."

The importance of this is emphasized in the following pertinent quote from the *Connecticut State Medical Journal,* entitled, "How to Vote Between Elections":

"Election day is the only day you can vote for candidates. But there are hundreds of days when you can vote for representative government.

"Every time you make your views known to your legislators (state or national), you are voting for good government. They can act with resolution when they know what their constituents think."

ADVICE ON SELECTING MEDICAL TEACHERS

Those who are engaged in teaching medical students should read the article by Dr. E. H. Watson, associate professor of pediatrics and child health, University of Michigan Medical School, in the May issue of *The Journal of Medical Education,* official publication of the Association of American Medical Colleges.

In our opinion, Watson's evaluation of medical teachers offers some good suggestions not only for medical teachers but for medical administrators who have a voice in the selection of medical teachers.

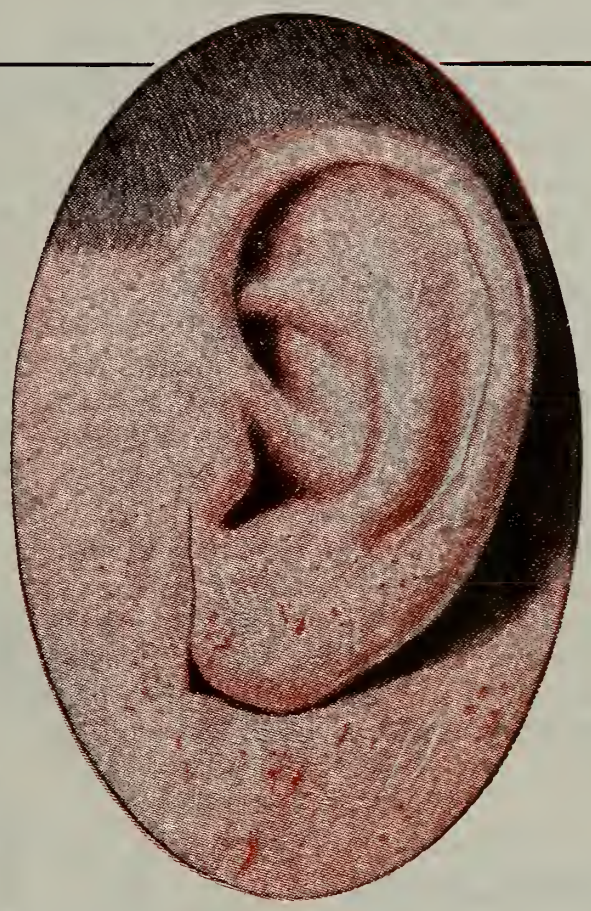
Among other things, Dr. Watson says the good teacher gives the student far more than scientific training. He teaches the doctor-to-be that wisdom and understanding are important attributes for a physician and that sick people are fellow human beings in trouble, Watson emphasized. Dr. Watson also suggests that one of the responsibilities of a good medical teacher is to study his students and junior staff members in an effort to help them find the phase of medicine

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for which they are best suited. Often the brilliant researcher or successful clinician is not always a topnotch teacher, Dr. Watson concludes.

YOUR LOCAL EPH COMMITTEE NEEDS YOUR COOPERATION

Plans are being laid by the Ohio Employ the Physically Handicapped Committee to organize committees in every community of the state. This is a fine idea and should have the support of the medical profession.

Promotion of employment of the physically handicapped is a job of primary importance and a year-round project. There is work to be done in every community. Nothing will be done without an organization—a sparkplug.

As evidence of the need for cooperation by the medical profession and the desire of the state committee to have it, is the following comment which appeared in the June 15 News Letter of the EPH Committee:

"Without a doubt, the medical profession can help us greatly to promote the cause of the handicapped. Our suggestion is that every committee make special efforts to enlist the aid of physicians and surgeons. If you have a medical man in your community who is doing an outstanding job, by all means nominate him for a physician's award. Just submit the facts to your State Inter-Agency Committee Chairman. It will be mighty good promotion for your committee."

It is suggested that county medical societies give their support to their local Employ the Physically Handicapped Committee. Nothing can be more important than helping to get the handicapped squared away into a job where they can become self-supporting and a productive part of our economy.

TIME FOR A CLEAN-UP OF ADVERTISING MATERIAL

Needless to say the medical profession as well as the public is fed up on the growing tendency in advertising circles to feature stethoscopes, white coats and medical claims in advertising programs. For that reason an editorial on this subject in a recent issue of *The Journal of the A.M.A.* is quite timely.

The Journal of the A.M.A. infers that "this is a cheap attempt to mislead the audiences into believing that the claims have been proved medically" and adds: "While advertisers may claim that the medical profession makes up only a small part of the total population, they should not forget that the doctors' voices can be heard in ever-widening circles and that the public is not so lastingly gullible as some advertisers seem to believe."

At the recent A.M.A. meeting in New York, the House of Delegates adopted a report that this question be studied by the Board of Trustees and that conferences be held with radio and television officials to try to effect a clean-up.

Local medical societies which are working with local radio and T.V. stations on health education projects have a splendid opportunity to get in some good licks. The stations are not entirely to blame as they too are at the mercy of high-pressure advertising copy writers. Nevertheless, they could demand that the copy writer stay within the bounds of accuracy and propriety. A fed-up public is not good for either the station or the advertiser.

PRACTICAL TRAINING FOR FUTURE M. D.'S

Seniors in the University of Wisconsin's Department of Preventive Medicine and Student Health spend three and one-half days in an industrial plant that has a functioning health program. With the plant physician, they discuss and observe the handling of occupational hazards, industrial poisons, safety programs, noise control, sanitation, personnel problems, job placements for the handicapped, care of common injuries and the like.

This practical project makes a lot of sense. Undoubtedly, the time spent is far too short but in the end, better than trying to secure industrial health facts and procedures solely from books. More medical schools should endeavor to tie into their courses on-the-job training of this kind.

RESEARCH GRANTS NOT ALWAYS BLESSINGS, STUDY SHOWS

Before a medical school starts jumping up and down with glee upon receiving word that it has been the recipient of another research grant, it should sharpen its pencil and start figuring. Such grants may not be the blessings which they may appear to be at first glance.

For every dollar a medical school accepts in research grants, it has to dig down in its own pocket for an average of 35 to 40 cents to meet indirect costs, a recent study indicates.

The National Foundation for Infantile Paralysis analyzed data on 91 polio research grants to 33 institutions, mostly medical colleges. It found that indirect costs ranged from 13 to 155 per cent of the direct cost. Generally the smaller the grant, the larger the proportion of indirect costs. Reporting on the study, Dr. Harry M. Weaver, NFIP director of research, said: "In all too many instances in the past these added costs have been met by using funds intended primarily for educational purposes."

He suggests that grant-making agencies defray approximately 90 per cent of the total costs of research projects by adding to the original grant 46 per cent for the first $10,000, then 38 per cent for the next $20,000 and six per cent for everything above that.

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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

After completing two days of preliminary hearings on possible social security revisions, the House Ways and Means subcommittee headed by Rep. Carl T. Curtis, has adjourned until November 2. It is said that the group intends to re-examine the fundamental conditions on which the social security law is based.

* * *

Rep. Clarence Brown, Blanchester, Ohio, veteran Republican Congressman, has been named a member of a new Commission on Organization of the Executive Branch of the Government. With former President Herbert Hoover slated to be chairman this group is to take up where the old Hoover Commission left off in 1949. Arthur S. Flemming, Director of the Office of Defense Mobilization, on leave as president of Ohio Wesleyan University, is also on the Commission.

* * *

Dr. Francis J. Braceland, chief psychiatrist at the Hartford (Conn.) Institute of Living, has been appointed by the President as a member of the Health Resources Advisory (Rusk) Committee to succeed Dr. James C. Sargent, resigned. Dr. Sargent will continue to act as a consultant however.

* * *

In collaboration with three groups, the Public Health Service has begun a national study of the efficacy of gamma globulin used this year against poliomyelitis. Cooperating are the Association of State and Territorial Health Officers; the American Physical Therapy Association, and the D. T. Watson School of Physiatrics, affiliated with University of Pittsburgh School of Medicine.

* * *

The Hill-Burton hospital construction program is getting $65 million for this fiscal year, which is $15 million more than the House voted, and $10 million less than the Senate-approved total. This is one of the items in the Department of Health, Education, and Welfare's budget of $1,738,399,261, which cleared Congress in the final days of the first session.

* * *

President Eisenhower has appointed Dr. Melvin A. Casberg to be Assistant Secretary of Defense for Health and Medical Affairs, a position long advocated by the A. M. A. Dr. Casberg, former dean of St. Louis University Medical School, will supervise the department's medical programs and advise the Secretary of Defense on Health Policies. He has been serving as a special assistant to the Secretary.

* * *

The position in the Department of Health, Education, and Welfare now held by Wilbur J. Cohen, has been placed in "Schedule C," the policymaking bracket which is outside protection of Civil Service.

* * *

Dr. Howard Karsner, former Cleveland pathologist and medical research advisor to the Navy Surgeon General, is new chairman of the Leonard Wood Memorial Advisory Medical Board.

* * *

Ground was broken recently for the first of ten hospitals which the United Mine Workers is building in West Virginia, Virginia and Kentucky. This one at Beckley, West Virginia.

* * *

The Veterans Administration's reorganization plan, first outlined last winter, will go into effect September 7. Acting V. A. Administrator H. V. Stirling has said that Vice Admiral Joel T. Boone will continue as chief medical director of the Department of Medicine and Surgery as at present, and assume direction of the Special Services Branch, which supervises chaplains, libraries, canteens and recreation.

* * *

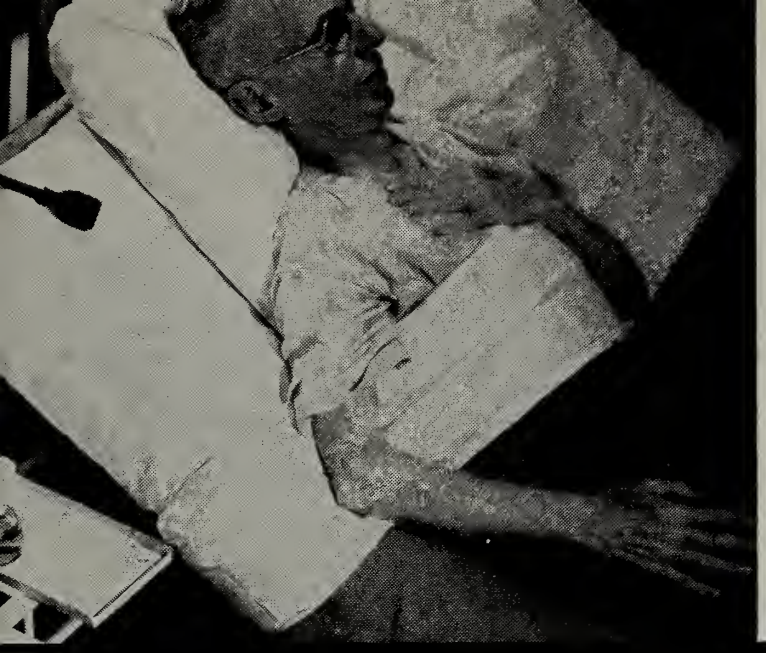
The Senate Foreign Relations Committee received assurances from State Department officials that in negotiating future bilateral treaties the administration will seek to write in exemptions for the professions, including medicine, from the most-favored-nation clause. A number of professional groups have been concerned over treaties granting reciprocal rights for practice without regard to state licensing regulations.

* * *

Dr. E. J. McCormick, Toledo, president of the A. M. A., was among those who testified recently before the House Ways and Means Committee in favor of legislation to grant income tax deductions to physicians and other self-employed persons for premiums paid for retirement insurance.

Years of Schooling

In 1950 women at ages 25 and over had on the average 9.6 years of schooling compared with 9.0 years for men. For women the average years of school completed increased by almost one year in the past decade, while for men the rise was not quite one half year, according to Bureau of the Census data.—*Metropolitan Life.*



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"Morbidity from apparent genito-urinary causes was noted in only one patient of 44 patients who received prophylactic Terramycin."[3]

"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[2]

1. Ferguson, C., and Miller, C. D.: J. Urol. *67*:762 (May) 1952.
2. Trafton, H. M., and Lind, H. E.: Ibid. *69*:315 (Feb.) 1953.
3. Blahey, P. R.: Canad. M. A. J. *66*:151 (Feb.) 1952.

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Internship Matching Program Enters Second Year

On July 1 more than 6,000 new doctors from U. S. medical schools begin internships at hospitals throughout the country. As a result of a national matching plan, now in its second year of operation, 95 per cent of the interns will complete their formal medical training at the hospital of their first or second choice, according to a report on the recently completed program in *The Journal of Medical Education.* Eighty-five per cent of the students received their first choice internship.

The national matching plan was set up last year to lessen difficulties caused primarily by the disparity between the number of internships and doctors available to fill them. The difference between the number of internships and available new doctors continued this year at about the same rate. While 6,033 students participated in the plan, some 10,971 internships were offered.

The plan places no restrictions on the student as to the number of internships for which he may apply, or on hospitals for the number of internships they may offer. Both students and hospitals are free to negotiate with each other in the normal competitive American fashion, short of actually signing a contract.

Students apply directly to the hospitals, then send to the matching program headquarters in Chicago a list of the internships for which they applied, in order of preference. Hospitals do the same with applications they receive.

Matching was successful for the 28 couples participating this year. Upon request, married and engaged couples are matched to the same hospital.

Operating under a new name, the National Intern Matching Program, Inc., the corporation is owned and controlled by the Association of American Medical Colleges, Council on Medical Education and Hospitals of the American Medical Association, American Hospital Association, American Protestant Hospital Association and the Catholic Hospital Association. It was known formerly as the National Interassociation Committee on Internships. The directors include student representatives. Various government services are also represented.

Films Cleared For Television

The A. M. A. Committee on Medical Motion Pictures has announced the publication of a supplement to the list of health education motion pictures cleared for use on television. This supplement lists 38 motion pictures which have been cleared for television use since publication of the original list in 1951. Copies may be obtained by writing to the committee.

Do You Know? . . .

Burdett Robert Whitaker, 18-year-old son of Clem Whitaker, who managed the American Medical Association's National Education Campaign for four years, was drowned in a Fourth of July swimming accident in California.

* * *

Dr. Thomas D. Dublin has resigned as executive director of the National Health Council, a nonprofit organization of national voluntary health agencies. No decision had been made as to his successor as this issue went to press. Three vacancies on the Council's executive committee were filled with the following appointments: Mason H. Biglow, president, National Society for the Prevention of Blindness; James T. Nicholson, executive vice-president, American National Red Cross, and Dr. Hart E. Van Riper, medical director, National Foundation for Infantile Paralysis.

* * *

John J. Raymond, Minneapolis, has joined the A. M. A. Bureau of Medical Economic Research as associate in sociology. The Bureau is directed by Frank G. Dickinson, Ph. D.

* * *

Dr. Elmer L. Henderson, Louisville, Ky., Past-President of the American Medical Association and for many years a leading figure in national medical organization work, died on July 30, after a long illness. He was 68.

* * *

Dr. Ernest B. Howard, assistant secretary of the American Medical Association, has been named to serve as a member of the Committee on Social Legislation of the Chamber of Commerce of the United States.

* * *

Volume 50, *Quarterly Cumulative Index Medicus,* which covers the literature for the last half of 1951, is now available for purchase from the American Medical Association Order Department, 535 N. Dearborn St., Chicago 10. The next volume is in production and should be completed by the end of the year.

* * *

Dr. Elizabeth Kuffner, St. Marys, late in July became the second woman in the Nation to join the regular U. S. Army as a medical officer when she was sworn in in the rank of major. The Army only a few weeks previously lifted the ban on women in the medical corps.

* * *

Dr. W. M. Hoyt, Hillsboro, has been reappointed by Governor Frank J. Lausche to serve his third seven-year term on the State Medical Board.

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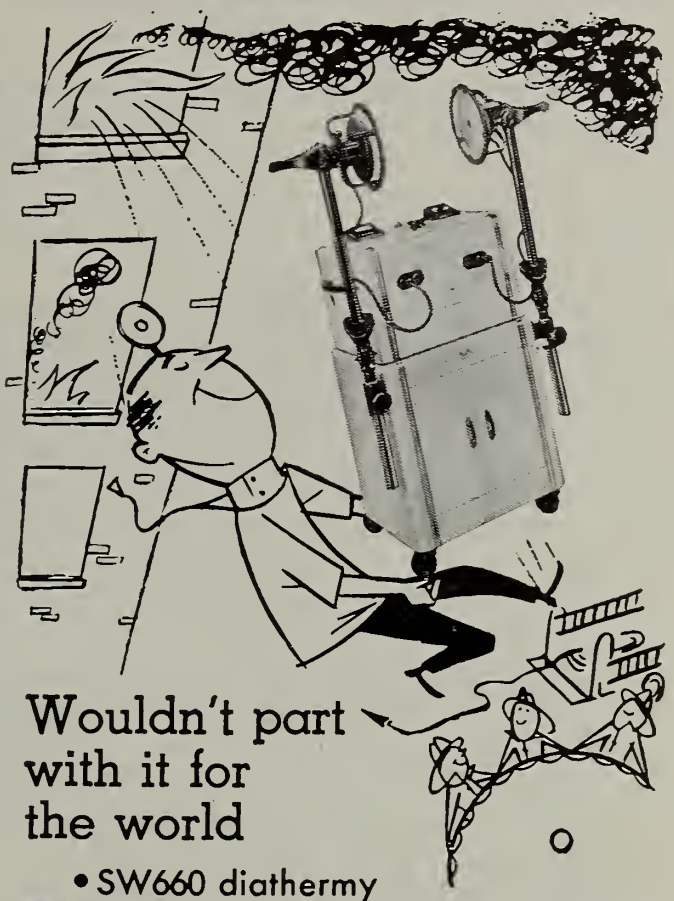
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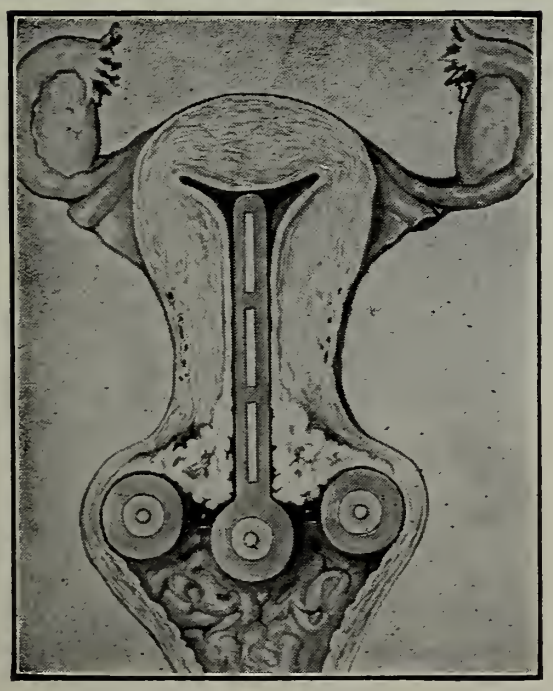
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A. M. A. Clinical Session To Be Held In St. Louis, December 1-4

The Jefferson Hotel has been selected as the headquarters hotel for the American Medical Association's annual Clinical Session in St. Louis, Dec. 1-4. The House of Delegate sessions will be held in the Gold Room of that hotel. All reference Committees will also meet there.

Dr. Llewellyn Sale, chairman of the Local Committee on Arrangements, says that from all indications the meeting will be an outstanding one. All scientific activities will be held in Kiel Auditorium, where there are ample facilities for the lecture program, scientific exhibit, technical exposition, motion picture program, and television program.

Dr. Daniel L. Sexton, subchairman in charge of clinical presentations, has nearly completed the program for clinical presentations and color television. These will cover the fields of medicine, surgery, pediatrics, obstetrics and gynecology, tuberculosis and other diseases of the chest, cardiovascular diseases, arthritis, dermatology, gastrointestinal diseases, and neuropsychiatry.

Arrangements for color television, to be presented through the cooperation of Smith, Kline and French Laboratories, have been completed, but the showing of this program at the meeting will depend on the settlement of a jurisdictional dispute between two labor unions at the auditorium.

The scientific exhibit will be correlated as far as possible with the clinical presentations. Besides a group of 75 or 80 exhibits on the above subjects, there will be several special features. A special exhibit on fractures will be shown as usual under the direction of the fracture exhibit committee, composed of Dr. Gordon M. Morrison, Boston, chairman; Dr. Ralph G. Carothers, Cincinnati, and Dr. Herbert Virgin, Jr., Miami, Florida.

A contemplated feature is an exhibit symposium on the prevention of traffic accidents. This will include the responsibility of the physician in telling his patient when not to drive and what other precautions should be taken in special situations, the testing of the drinking driver, precautions to be taken by automobile manufacturers in the reduction of mechanical hazards, and the care of the injured by physicians after an accident.

Medical motion pictures will be shown continuously. The authors will be present, whenever possible, to discuss their work.

Dr. Robert M. Inglis, Columbus, was elected to the Board of Trustees of the Central Hospital Service, Blue Cross Plan, with headquarters in Columbus. Dr. Gilman D. Kirk, Columbus, is a member of the Board.

New Members of O. S. M. A.

The following are the names of new members of the Ohio State Medical Association since July 10, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ADAMS COUNTY
Salamon, Alexander, Seaman

BELMONT COUNTY
Masor, K. A., Bellaire

CLARK COUNTY
Beam, Robert B., Springfield
Lehmenkuler, Charles F., North Hampton

CLERMONT COUNTY
Miller, Donald Eugene, Loveland

CUYAHOGA COUNTY
Gardner, Robert E., Cleveland
Greene, George J., Cleveland
Horrocks, Jack B., Cleveland
Kovacs, Imrich, Cleveland
Nelson, Richard M., Jr., Chagrin Falls
Slade, Harry W, Cleveland

FAIRFIELD COUNTY
Dowdy, Fred A., Lancaster

HAMILTON COUNTY
Brockmeier, Frederick, Cincinnati
Floyd, Henry L., Cincinnati
Hawley, Donald K., Cincinnati
Kay, Sidney A., Cincinnati
Suder, Garfield L., Cincinnati

LORAIN COUNTY
Grauel, John E., Lorain

LUCAS COUNTY
Chilmonczyk, Walter, Toledo
Neufeld, Oscar, Toledo
Swoyer, Grover, Toledo
Tonney, Fred O., Toledo

MADISON COUNTY
Sparling, H. P., London

MAHONING COUNTY
Gasser, Louis J., Youngstown

PORTAGE COUNTY
Knight, Arthur L., Apco
Webb, Edward A., Ravenna

STARK COUNTY
Julius, Aristides D., Canton
Staudt, Charles E., Canton

SUMMIT COUNTY
Keeley, A. J., Akron

WAYNE COUNTY
McDowell, O. C., Orrville

Physician Is Named Special Assistant to Mrs. Hobby

The post of Special Assistant in Health and Medical Affairs to the Secretary of Health, Education, and Welfare goes to a prominent Boston physician, Dr. Chester Scott Keefer. Professor of medicine at Boston University School of Medicine, Dr. Keefer received his medical degree from Johns Hopkins University in 1922.

In addition to a long career in teaching, the new Special Assistant is an expert on antibiotics, supervising penicillin and streptomycin distribution for the U. S. and allies in World War II. He was chairman of the National Research Council's committee on chemotherapeutics which advised on civil defense medical stockpiling. Dr. Keefer has been physician-in-chief at Massachusetts Memorial Hospital since 1940.

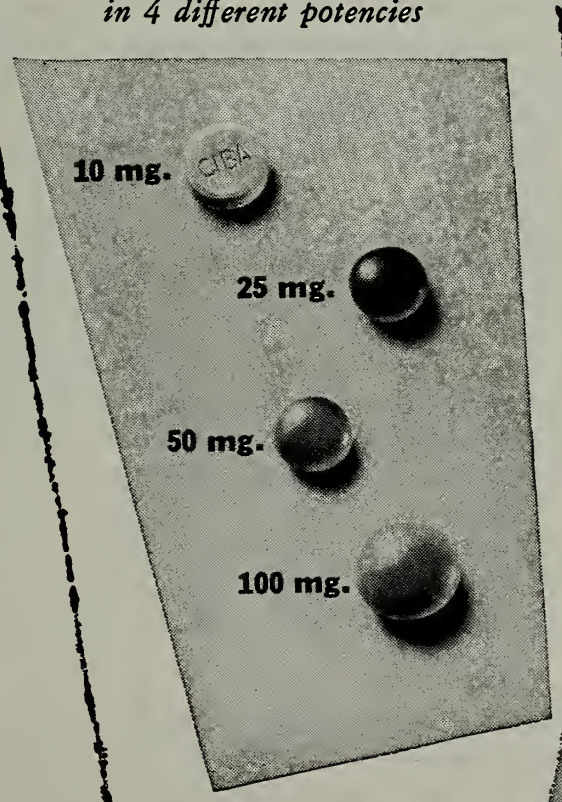
He is a fellow of the American College of Physicians, a member of the American Society of Clinical Investigation and has served on the American Medical Association's Council on Pharmacy and Chemistry. Under terms of Reorganization Plan No. 1 creating the Department, the Special Assistant is charged with reviewing and advising the Secretary on all health and medical programs of the department as well as on health and medical legislation.

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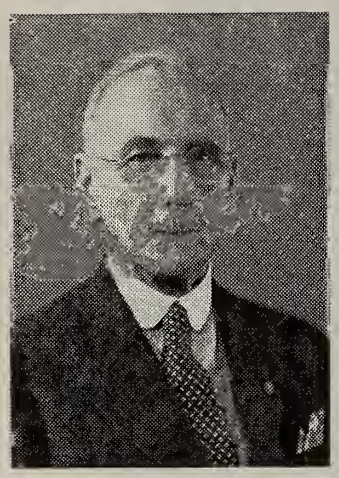
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In Memoriam . . .

Daniel C. Houser, M. D., Urbana; Starling Medical College, Columbus, 1897; aged 86; former President of the Ohio State Medical Association; member of the American Medical Association; died August 4. Ohio lost an outstanding practitioner and a tireless worker in behalf of organized medicine in the death of Dr. Houser.



D. C. HOUSER, M. D.

A native of Millersport in Champaign County, Dr. Houser opened his practice there upon completion of his medical schooling in 1897. In 1906 he moved to Urbana and practiced there continuously with the exception of time served in the Army Medical Corps with the rank of major during World War I. In his local Medical Society, Dr. Houser served three times as president and numerous times on local committees, among them the Committee on Public Policy and Legislation and later the Legislative Committee, the Committee on Public Relations and the Committee on Medical Economics.

In 1948, the House of Delegates of the Ohio State Medical Association, meeting in Cincinnati, paid tribute to Dr. Houser for having served continuously 46 years in the House. He had since increased that record to more than 50 years. He was a recipient also of the State Association's 50-Year Pin.

Dr. Houser was first elected Councilor of the Second District in 1925 and served in that capacity until he was named President-Elect of the Association in 1930. He served as President the following year. Among other contributions to the State Association was his service with the Committee on Public Relations and Economics.

In spite of his work as a physician, Dr. Houser found time to take an active part in the civic and fraternal life of the community and State. He served as director of public safety for the city of Urbana and held the post of president of the City Council. In 1928 he was a delegate to the Democratic National Convention held in Houston, Texas. Fraternal affiliations included the Masonic Lodge and the Odd Fellows. Surviving are a daughter; a son, D. L. Houser, D. D. S.; and a brother, all of Urbana.

Howard E. Busching, M. D., Wyoming, (Ohio); University of Cincinnati College of Medicine, 1920; aged 58; died July 7. A practicing physician in the Cincinnati area since he completed his medical education, Dr. Busching was for 28 years medical examiner for the Metropolitan Life Insurance Company and other insurance companies. His widow survives.

James R. Caywood, M. D., Piqua; Starling Medical College, Columbus, 1897; aged 84; died July 2; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Caywood began his practice in Lockington (in Shelby County) and moved to Piqua in 1901. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a 32nd Degree Mason and a member of the Presbyterian Church. Surviving are his widow, three sisters and a brother.

Warren Deweese Coy, M. D., Youngstown; Eclectic Medical College, Cincinnati, 1897; aged 81; died July 16; member of the Ohio State Medical Association; Fellow of the American College of Surgeons; past-president of the Mahoning County Medical Society and its delegate in 1923. Dr. Coy first practiced his profession in Canfield and in 1911 moved to Youngstown where he continued in practice until his retirement in 1946. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. For many years he had been active in the Unitarian Church and was a past-president of the Unitarian Laymen's League. His widow survives.

William F. Drake, M. D., Columbus; Ohio State University College of Medicine, 1922; aged 56; died July 19; member of the Ohio State Medical Association; member of the American Medical Association. After completing his internship, Dr. Drake practiced for four years in New Lexington and then returned to Columbus where previously he had resided. He was a member of Alpha Kappa Kappa, the Catholic Church, the Order of Foresters, the Order of St. Dominic and the Holy Name Society. Survivors are his widow, two sons, three daughters, three brothers and a sister.

David M. Johnson, M. D., Columbus; Jefferson Medical College of Philadelphia, 1922; aged 54; died May 14; member of the Ohio State Medical Association; member of the American Medical Association; member of the American Academy of Ophthalmology and Oto-Laryngology; diplomate of the American Board of Otolaryngology. Dr. Johnson was a commander in the U. S. Navy during World War II.

James P. Keane, M. D., Cleveland; St. Louis University School of Medicine, 1948; aged 30; died July 30 in an airplane accident; member of the Ohio State Medical Association; member of

the American Medical Association. Dr. Keane had been a practicing physician in Cleveland before he was called into service early this year. He was serving as a first lieutenant with the 91st Medical Group at Lockbourne Air Base, Columbus. He also was a veteran of World War II, a member of the Catholic Church and the Knights of Columbus. Surviving are his widow, four children and his parents.

Monford R. Kellum, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1901; aged 76; died July 20; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Kellum began his practice in Royalton 52 years ago and moved to Cleveland in 1918. In 1951 he was honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. Affiliations included membership in the Masonic Lodge. Survivors include his widow, a son and a daughter.

Wilbur Wayne Lucas, M. D., Tiffin; Starling Medical College, Columbus, 1904; aged 72; died July 18; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Lucas practiced for about 15 years in New Washington before he moved to Tiffin 33 years ago. He was a member of several Masonic bodies and a member of the Evangelical and Reformed Church. Surviving are his widow, a daughter, a son, a step-son and a sister.

Levi Emerson Miley, M. D., Grand Rapids, Mich.; University of Michigan Medical School, 1881; aged 101; died July 17. A native of the Wauseon area, Dr. Miley practiced there before he moved to Chicago in 1893. He retired from practice in 1933 after 40 years in Chicago and moved to Grand Rapids. Burial was in the Wauseon cemetery.

Arthur F. McQueen, M. D., Amherst; University of Wooster, Medical Department, Cleveland, 1911; aged 69; died July 18; member of the Ohio State Medical Association. Dr. McQueen's practice in Amherst dates from 1913 and was continuous with the exception of time served in the Medical Corps during World War I. In 1951, Dr. McQueen was named "Man of the Year" by the local Chamber of Commerce and the same year was presented a gold watch by the staff of Amherst Hospital. He was a member of the Congregational Church, the American Legion and the Masonic Lodge. Surviving are his widow, a daughter and a sister.

John A. Schirack, M. D., Canton; Physio-Medical College of Indiana, 1894; aged 92; died July 21; former member of the Ohio State Medical Association, last in 1920. Dr. Schirack began his practice in Decatur, Ill., but within a short time moved to St. Henry (Mercer County). He moved to Canton in 1920 where his principal work was that of insurance examiner. He was a member of the Catholic Church and the Knights of Columbus. Surviving are three daughters and three sons, including Dr. C. J. Schirack, Canton, and Dr. R. D. Schirack, Detroit, Three of his grandchildren also are physicians.

Howard K. Shumaker, M. D., Bellevue; Starling Medical College, Columbus, 1894; aged 81; died July 27; member of the Ohio State Medical Association; member of the American Medical Association; vice-president of the Huron County Medical Society, 1921; its president in 1924 and 1949, also active on several Society committees. After completing his medical education, Dr. Shumaker practiced for a few years at Old Fort (Seneca County) and then went to China, where he had been born, as a medical missionary. After seven years in China he returned home for health reasons, practiced for a while in Flat Rock (Seneca County) and in 1910 moved to Bellevue. He was a member of the Reformed Church and was active in religious work at the Y. M. C. A. He was president of the local school board for many years, president of the board of health and director of the local Red Cross chapter. A sister survives.

Frank Earl Stevenson, M. D., Cincinnati; University of Cincinnati College of Medicine, 1923; aged 58; died July 9; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Pediatrics. Dr. Stevenson returned after serving during World War I to complete his education. He continued postgraduate training at the University of Cincinnati and successively was instructor, assistant professor and associate professor in pediatrics. In 1937 he was exchange professor of pediatrics at Duke University and was made an honorary member of Phi Beta Kappa, also he was a member of Alpha Omega Alpha. Affiliations included membership on the Medical Advisory Board of Hamilton County Chapter, National Foundation for Infantile Paralysis and the Presbyterian Church in which he was an elder. Surviving are his widow, a son, a daughter, a sister and four brothers, one of whom is Dr. Jean M. Stevenson, Cincinnati.

Walter J. Urbanski, M. D., Cleveland; Ohio State University College of Medicine, 1938; aged 45; died July 8; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Urbanski during World War II served for four and a half years with the Medical Corps and attained the rank of major. His practice since the war was in Cleveland. Affiliations included Omega Upsilon Phi, the Chagrin Valley Country Club, the Catholic Church and the Catholic War Veterans. Surviving are his widow, two sons and his mother.

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Activities of County Societies . . .

ADAMS

Dr. R. L. Lawwill and Dr. Samuel Clark were hosts to members of the Adams County Medical Society and their families at the Knights of Pythias Hall in Cherry Fork on June 1. Guest speaker was Dr. Frank H. Mayfield, Cincinnati.

BELMONT

The Belmont County Medical Society met with the Auxiliary at Belmont Hills Country Club on June 18 for dinner and a program. Speaker for the occasion was Dr. Phillip Reagan, Institute of Pathology, Cleveland, whose subject was "The Cellular Detection of Cancer."

GREENE

Dr. W. W. Webb, Dayton, spoke on the subject, "Diagnostic Procedures in Cancer—Specifically Bronchoscopy and Esophagoscopy," at the June 11 meeting of the Green County Medical Society in Greene Memorial Hospital, Xenia.

Dr. A. T. Anton, Springfield, spoke on the subject, "Infectious Hepatitis," at the July 9 meeting of the Society.

LORAIN

An address on "Allergy" was given by Dr. A. F. Piraino, Oberlin, at the June 9 meeting of the Lorain County Medical Society at the Pueblo, Lorain.

TUSCARAWAS

"The Chemotherapy of Tuberculosis," was the subject discussed by Dr. Joseph B. Stocklin, director of Sunny Acres Sanitarium and controller of Tuberculosis for Cuyahoga County, at the July 9 meeting of the Tuscarawas County Medical Society.

American College of Surgeons To Meet in Chicago

More than 11,000 surgeons, other physicians and guests are expected to attend the 39th annual Clinical Congress of the American Congress of Surgeons to be held in Chicago, October 5 through 9.

Dr. Harold L. Foss, president of the American College of Surgeons for 1953, will preside at the opening evening session at which Dr. Fred W. Rankin, Lexington, Kentucky, will be installed as president for the year 1954. Dr. Evarts A. Graham, St. Louis, chairman of the Board of Regents, will introduce special guests and Sir James Paterson Ross, London, England, will give the Eighth Martin Memorial Lecture, entitled "Science and Surgery."

Additional information may be had from the College at 40 East Erie St., Chicago 11, Ill.



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GYNECOLOGY—Intensive Course, two weeks, starting Sept. 21. Vaginal Approach to Pelvic Surgery, one week, starting Nov. 2.

OBSTETRICS—Intensive Course, two weeks, starting Oct. 5.

DERMATOLOGY—Intensive Course, two weeks, starting Oct. 19.

MEDICINE—Electrocardiography & Heart Disease, two weeks, starting Oct. 12. Intensive General Course, two weeks, starting Sept. 28. Gastroenterology, two weeks, starting Oct. 26. Allergy, one month and six months, by appointment.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 28.

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Activities of Woman's Auxiliary . . .

By MRS. EDWARD L. VOKE, Chairman, Publicity Committee, 243 Hampshire Road, Akron 13, Ohio

President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House

Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima

Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

IN MEMORIAM

We regret the death of Adelaide (Oechsler) Beck, wife of Dr. W. W. Beck, of 2129 Richmond Road, Toledo, on July 18th. She was a past-president of the Auxiliary of Lucas County. Sympathy is extended to Dr. Beck.

* * *

Congratulations to our two new county units: the Pike County Auxiliary, organized in April by Mrs. A. Paul Hancuff, the state president-elect, and the Coshoction County Auxiliary, recently organized by Mrs. O. W. Jepson, the state vice-president.

ANNOUNCEMENTS

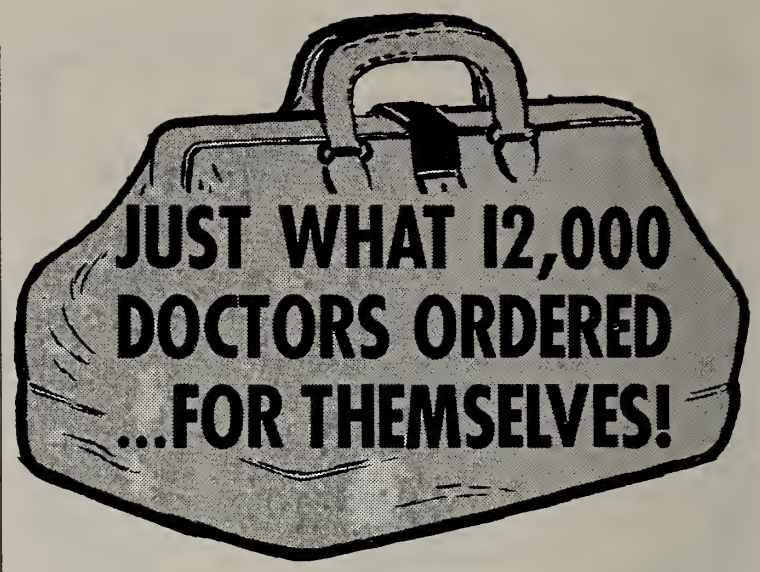
The Fall Conference for Presidents and Presidents-elect will be held September 29 at the Fort Hayes Hotel in Columbus with registration at 9:00 A. M. There will be a full day of workshop with luncheon at noon. The conference will be preceded by the board meeting on September 28th at the Fort Hayes Hotel at 3:00 P. M.

The annual meeting will be in Columbus also, April 13, 14, and 15, 1954, with the Auxiliary headquarters in the Southern Hotel.

LUCAS

Mrs. James E. Mullen, chairman of the yearbook committee, entertained the members of her committee for lunch at her home, 572 E. Front Street, recently. Plans for printing the thirteenth edition of the Auxiliary yearbook were discussed. Members of the committee who attended were: Mesdames Joseph M. Hertzberg, A. Rees Klopfenstein, George H. Lemon, John Smythe, Boni E. Petcoff, auxiliary president, and Howard Parkhurst, telephone committee chairman.

The co-chairmen for the Mothers' March on Polio in Lucas County are Mrs. John Buck and Mrs. Hazen L. Hauman, both of whom are members of the Auxiliary. Other members of the committee from the Auxiliary include: Mesdames Albert Alter, William Becker, William Bonser, George Bova, William Eyster, Ernest Gottschalk, A. Paul Hancuff, A. W. Hemphill, Alex Johns, A. R. Klopfenstein, John Kelleher, Gustave Link,

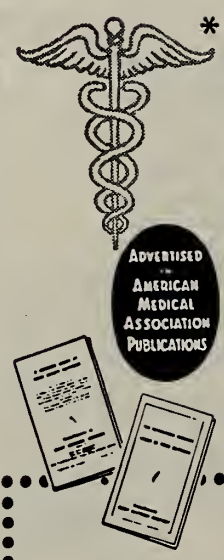




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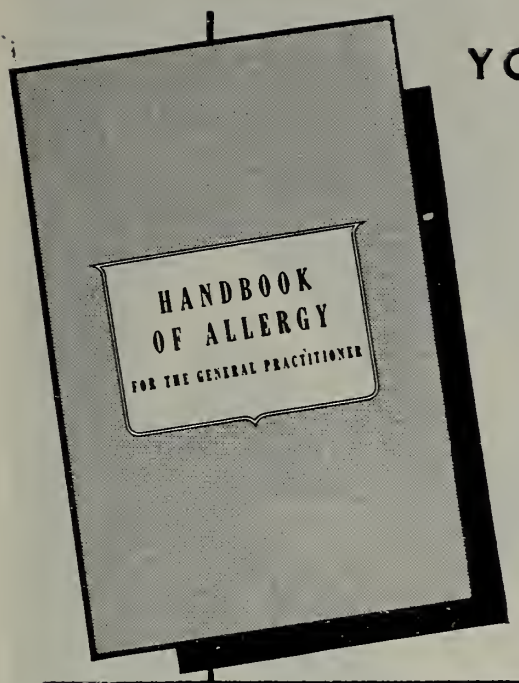
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C. W. McNamara, jr., M. G. Means, Ben Schulak, Robert Slotterbeck, R. H. Snyder, H. H. Stevens, and Theodore Zbinden.

During July, the committee on nurse recruitment was entertained at luncheon in the Sylvanian Country Club by Mrs. Myron Means. The guests were Mesdames L. S. Pugh, co-chairman; I. W. McConnell, George Bates, J. L. Westhaven, John Burnette, W. H. Meffley, E. F. Ward, jr., and Boni E. Petcoff, the Auxiliary president. The Auxiliary plans to select a student nurse each year to receive a three year scholarship for training in one of Toledo's approved hospitals.

The program for the year is being planned by Mrs. C. J. A. Paule and Mrs. Norman B. Muhme, co-chairmen. They are being assisted by Mesdames R. J. Borer, W. Leroy Bryant, Harry G. Conn, Charles B. Forrester, Emidio L. Gaspari, Joseph Hertzberg, Edward J. McCormick, and Donald F. McGrath. The group met for lunch recently at the home of Mrs. Paule, who was assisted by Mrs. Muhme.

Former chairmen of the Auxiliary fund raising committee, Mrs. Bernard S. Dunham, Mrs. Emidio Gaspari, Mrs. C. J. A. Paule, Mrs. Joseph Hertzberg, Mrs. Hazen L. Hauman, and Mrs. Carl Dreyer with Mrs. Petcoff completed the purchase of equipment needed for the Academy of Medicine Building on July 21. Mrs. Dreyer, who was in charge of the purchasing, entertained the others at luncheon.

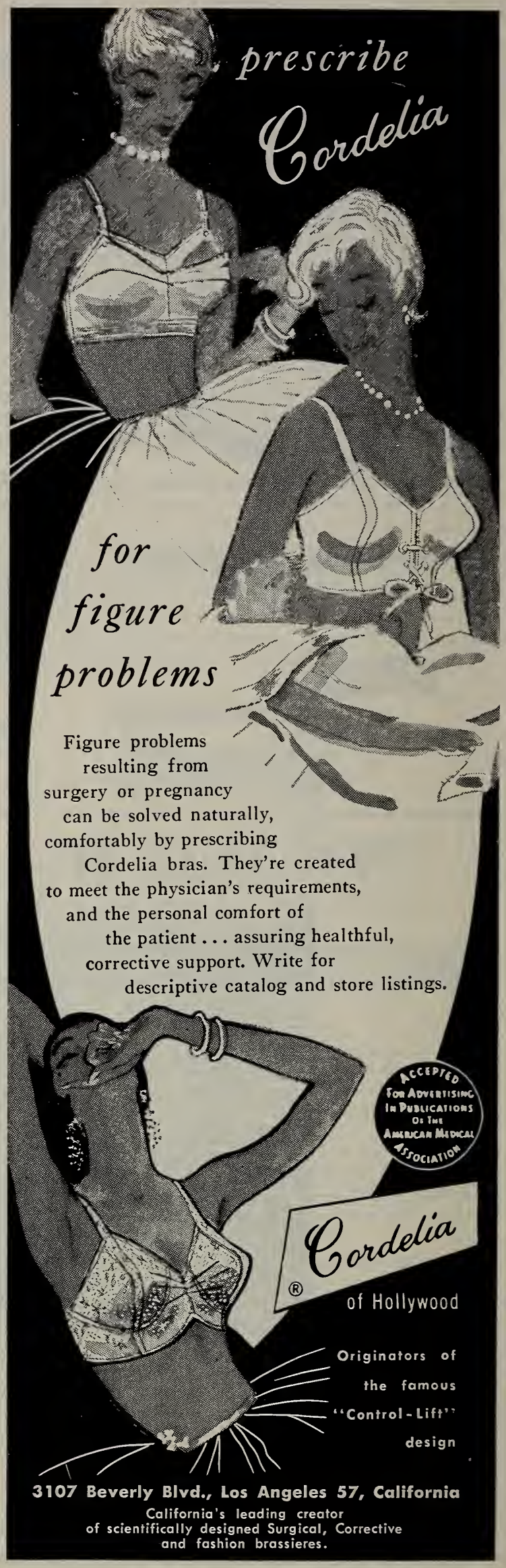
RICHLAND

The June meeting of the Executive Board of the Richland County Auxiliary was held at the home of the president, Mrs. Paul A. Blackstone, Mansfield, O. Other officers are Mesdames Albert Voegele, past-president; Robert W. Wolford, president-elect; Karl T. Langacher, vice-president; Paul Lee, treasurer; P. O. Staker, Recording secretary; and Robert Pierce, corresponding secretary.

The new committee chairmen include the following: Mrs. C. M. Quick, finance and point system; Mrs. Edward Beilstein, *Today's Health*; Mrs. H. G. Knierim, public relations; Mrs. Donald Dewald, legislative; Mrs. D. W. Peppard, historian; Mrs. Wendell Bell, ways and means; Mrs. L. A. Hautzenroeder and Mrs. Joseph B. Edelstein, radio and visual education; Mrs. Hall S. Weidemer, social; Mrs. Wolford, organization; Mrs. Langacher, program; Mrs. Lee, bulletin; and Mrs. Staker, publicity.

SUMMIT

The committees for the second annual "Hobby Show for Oldsters" to be held in September, are as follows: Advsiory, Miss Gladys Williams, Mr. Carl Warmington, and Mrs. N. E. Wentsler; Public Relations, Mr. R. L. Shaeffer, Mrs. C. R. Graham, Miss Ann Doran, Mrs. Nathan Gordon, Mrs. Fred W. Dixon, Mrs. E. W. Kissel, Dr. N. S. Elderkin, Mr. W. R. Herner, and Mrs. R. E. Yeakley; Contact, Mrs. Frank T. Moore, Mrs.



Duane Banks, Mrs. Glenn V. Hough, and Mrs. E. R. Graham; Check-in, Mrs. E. L. Mollin, Mrs. Fred W. Dixon, Mrs. Nathan Gordon, Mrs. C. A. Raymond, Mrs. George Bischoff, Mrs. R. R. Pliskin, Mrs. William Davis, and Mrs. Carroll F. Tatum; Display, Mrs. Glenn V. Hough, Mrs. L. M. Weinberger, Mrs. Carl T. Korsmo, Mrs. Robert Lemmon, Mrs. Richard Gregg, Mrs. Patrick Doran, Mrs. Wilbur C. Robart, Mrs. Frank Karg, Mr. R. C. Jones, Mrs. A. W. Friend, Mrs. L. E. Brown, and Mrs. Gerald Quinn; Reception and Hostesses, Mrs. Walter A. Hoyt, Jr., Mrs. Edward L. Voke, Mrs. Doran, Mrs. Duane Banks, Mrs. C. F. Wharton, and Mrs. Edwin Grubb; Award, Mrs. R. B. Sommerfield, Mrs. Robert Brubaker, Mrs. R. M. Rees, and Mrs. Edward R. Blower.

Mrs. Arthur Dobkin, president-elect, is chairman of the 1953 Hobby Show, which is cosponsored by the Summit County Auxiliary and the Council of Social Agencies.

TUSCARAWAS

The annual President's Dinner was held at the Reeves Hotel in New Philadelphia when the new officers were installed. Mrs. R. A. Wilson of Dennison assumed the presidency of the group and the other officers elected for the coming year were: Mrs. Paul Hahn, New Philadelphia, president-elect; Mrs. Harold Wherley of Stone Creek, vice-president; Mrs. Edward Miller, Dennison, secretary; and Mrs. Paul Ebert of Dover, treasurer. The committee in charge was composed of the retiring officers for the year, including Mrs. Wherley, Mrs. D. M. Ceramella, Mrs. E. C. Davis, Jr., all of New Philadelphia, and Mrs. Wilson.

During the dinner, vocal selections were given by Mrs. George Chrest, accompanied by Mrs. Baldwin, both of Uhrichsville. It was announced at the meeting that Mrs. H. F. Van Epps of Dover had been elected as the director of the Seventh District at the State meeting in Cincinnati.

Mrs. Wilson appointed the following committee chairmen: Program, Mrs. Paul Ebert of Dover and Mrs. Miller; ways and means, Mrs. Jay Calhoun of Uhrichsville; public relations and legislation, Mrs. Hahn and Mrs. S. H. Winston of Dover; publicity, Mrs. R. J. Foster; radio and visual education, Mrs. P. T. Doughton; project, Mrs. Ceramella; civilian defense, Mrs. C. R. Crawley of Dover; nurse recruitment, Mrs. Robert Rinderknecht of Dover; *Today's Health*, Mrs. F. C. Yeager of Dover; historian, Mrs. Benjamin Pilloff of Uhrichsville; gifts and cards, Mrs. C. J. Miller; tax stamps, Mrs. Charles Newell of Strasburg and Mrs. Alvin Greenlee of Uhrichsville; membership and telephone, Mrs. Myrtle Hahn of New Philadelphia, Mrs. Henry Engel of Dover, Mrs. W. H. Curtiss of Dennison, and Mrs. Dan Hostetler of Sugarcreek.

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Buckeye Notes . . .

Chillicothe—Dr. Nicholas H. Holmes is governor of Rotary International District 232.

Cleveland—A portrait of the late Dr. Thomas E. Jones, chief of surgery at Cleveland Clinic before his death in 1949, was presented to Cleveland Clinic by Dr. Robert E. Moran, of Washington, D. C., a lifelong friend. The portrait was painted by Bjorn Egli, of Washington.

Cleveland—Dr. Robert M. Hosler recently gave a course in cardiac resuscitation for the Pacific Coast Ophthalmological Society in Los Angeles, and other groups.

Columbus—Dr. Benjamin D. Osborn, who has practiced in Waldo and vicinity for 56 years, was the subject of a feature article in the *Columbus Dispatch.*

Columbus—Dr. John F. Switzer, New Straitsville, was the subject of a feature article in the *Columbus Dispatch.*

Fremont—Dr. E. W. Baker, retired, was guest of honor at a reunion of alumnae of the former Mary Miller Hayes School of Nursing. Dr. Baker taught at the school which closed in the early 1930's. Now 93 years old, he retired in 1950 after 60 years of practice.

Gallipolis—Dr. Oscar W. Clarke was elected president of the Gallipolis Rotary Club. The following physicians were among five honorary Rotarians named for the year: Drs. Charles E. Holzer, Sr., Norvil A. Martin and Leo C. Bean.

Gallipolis—Dr. William F. Ashe and Dr. J. Gordon Gibert described their experiences in Scotland and England before a meeting of District 14, Ohio State Nurses' Association.

Marion—Two Marion physicians were subjects of a feature article in the *Marion Star.* They are Dr. Eben L. Brady and Dr. Everett H. Morgan, both of whom have served 50 years in the profession.

Newark—Dr. Frank Clemson, Thornville, was the subject of a feature article in the *Ohio Advocate and American Tribune.* He has practiced in the Thornville vicinity since 1898.

Springfield—Dr. Martin J. Cook was recipient of the Junior Chamber of Commerce Distinguished Service Award for his significant contribution to the welfare of the community.

Toledo—The Northwestern Ohio Heart Association had as guest speaker Dr. Herman K. Hellerstein, Cleveland, who spoke on the subject, "Working With Your Heart." Dr. Hellerstein is director of the Work Classification Center for the Cleveland Heart Society.

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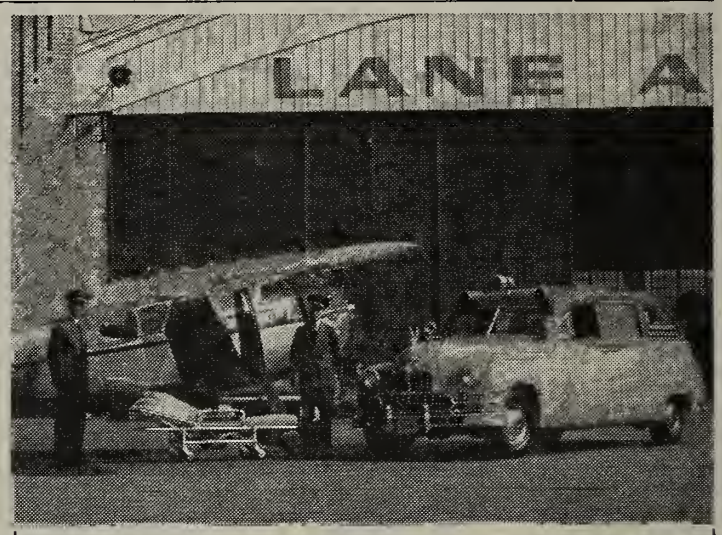
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Toledo, Dr. Guy F. Peabody, retired physician, was the subject of a feature article in the magazine section of the *Toledo Blade.*

Warren—Dr. Daniel C. Wunderman, staff physician at the Sunny Acres Hospital in Cleveland for several years, has been named head of the Trumbull County Tuberculosis Hospital.

Wellston—Dr. John L. Frazer was reelected president of the Wellston Public Library board for his fifth successive term.

Wilmington — Dr. Edmond K. Yantes was awarded the Silver Beaver Award for outstanding work in the Boy Scout movement. A worker of long standing as a Scouter, Dr. Yantes is now chairman of the Anthony Wayne District Committee which supervises Scouting in six counties.

Wooster—Dr. Vaughn L. Hartman, has been named Medina County health commissioner to succeed Dr. Earl Kleinschmidt, who resigned effective June 15. Dr. Hartman, who held the same position in 1936 and 1937, has been residing in Cleveland Heights.

Zanesville—Dr. Harry A. Martin, Gratiot, was the subject of one of a series of human interest features in the *Zanesville Times-Signal,* entitled "Interesting Folks in Southeastern Ohio."

Western Reserve Announces New Appointments and Promotions

A number of new appointments and promotions on the staff of the Western Reserve University School of Medicine have been announced.

Dr. W. F. H. M. Mommaerts, of Duke University, has been named associate professor in biochemistry. He has done extensive research work for the American Heart Association and in the field of muscle energy.

Dr. Henry Z. Sable, Tufts University School of Medicine, has been appointed assistant professor in the same department. His latest work has been in the field of enzymes.

Genevieve Miller, Cornell University, member of the board of editors of the Journal of the History of Medicine and Allied Sciences, will be assistant professor of medical history.

Dr. Guerino D. Novelli, Harvard University Medical School, becomes associate professor of microbiology.

Dr. Stephen S. Hudack, who recently came from New York City to head the surgical research division at St. Luke's Hospital, becomes assistant clinical professor of surgery.

The following promotions were announced:

Dr. Clarence H. Heyman, clinical professor of orthopedic surgery; Dr. Jack R. Leonards, associate professor of biochemistry; Dr. Robert E. Eckel, assistant professor of medicine;

Austin B. Chinn, associate professor of medicine; Howard Gest, associate professor of micro-

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Legislative Review (Continued) . . .

CONTINUED FROM PAGE 822

ures were vigorously opposed by the Ohio State Medical Association. For the first time since 1929, the perennial chiropractic bill got to the floor of the General Assembly. It came out of the House Health Committee by a vote of seven to six—seven votes being needed. It was laid on the table by the House by a vote of 57 to 55 and was put to sleep permanently when a motion to take the bill from the table was defeated, 62 to 55. The naturopathic bill was killed by the House Health Committee without even one public hearing.

To enact a food, drug and cosmetic law, similar to the uniform act in effect in a number of states. The need for revision of the present laws was recognized by many members of the General Assembly and by representatives of most of the outside interests affected. The bill passed the House but at hearings in the Senate, the various groups concerned could not agree on the wording and provisions of some of the sections of the proposal. As a result, it died in committee.

To set up drastic provisions to govern the administrative procedures of the state licensing boards. These bills were opposed by the O.S.M.A. and other organizations representing professions and trades. The result was the enactment of a constructive compromise bill, Sub. H. B. 256. (See reference in this article to H. B. 256.)

To increase the penalties for violation of the narcotic laws. Ten bills on this subject were introduced. The House Health Committee drafted them into a composite bill. This bill passed the House and was recommended for passage by the Senate Judiciary Committee but it failed to get on the Senate calendar for action before adjournment. There is reason to believe that some members of the Senate felt that the enactment of legislation should be delayed pending the investigation and report of the Attorney General on this subject, authorized by Senate Bill 33 which was enacted.

To liberalize the laws banning the sale and use of fireworks. This bill passed the Senate but died in the House Committee on Public Affairs after many protests had been filed by physicians, public health workers, welfare groups, etc.

To create a Division of Alcoholism in the Ohio Department of Health to carry on an educational and rehabilitation program. The measure passed the House but did not get on the Senate calendar for a vote.

To provide by law that counties shall establish programs for the care of the permanently and totally disabled, for which Federal funds are provided. The House passed the measure but it did not come to a vote in the Senate. Such programs are now in operation by "executive order" of the State Welfare Director.

To allow counties to appropriate funds for local mental health clinics which would be subject to control of State Welfare Department. The bill was passed out by the House Health Committee but recommitted on request of the sponsors. It died in committee.

To set up machinery for the examination and licensing of practical nurses. Two bills were introduced. One would have provided for examination and licensing of practical nurses by the State Nurses Board and would have recodified the Nurses Practice Act; the other called for the creation of a new board to examine and license practical nurses. Neither bill got out of committee because of radical differences of opinion within the ranks of the nursing profession and vigorous opposition to the whole idea by individual nurses and a few physicians. A bill to increase the State Nurses Board by adding two hospital administrators and an educator also died in committee.

To make an appropriation of about $3,000,000 to the State Department of Health for grants to hospitals amounting to $250 for each student nurse. The bill was never assigned to committee for hearings.

To increase medical and hospital care allowances for recipients of Aid for the Aged. Many bills on this subject were introduced, ranging from one to remove any ceiling on the allowances and others to increase the $200 per year allowance to $300 and to include nursing care. None was enacted as the state budget could not be expanded to meet the additional cost, in the opinion of the leadership of the Assembly. The only A. F. A. law enacted was one to increase the regular monthly award to recipients from $60 to $65.

To provide for the nomination and election of the county coroner on a nonpartisan ticket. Obviously, this bill had political implications. It did not get out of committee.

To establish a state system of compulsory disability insurance. It died in committee.

To impose drastic penalties on physicians, employers and others who fail to file Workmen's Compensation forms within a specified time. This was among a dozen or more Workmen's Compensation bills presented. It was not acted upon by the committee to which the measures were referred.

To permit the State Welfare Director to contract with physicians, including non-citizen phy-

sicians, for services at the state hospitals. Died in committee.

To transfer restaurant inspection from State Fire Marshall to State Department of Agriculture. Killed in committee. Bill to place restaurant inspection in hands of health departments was enacted.

To permit a probate court to void a decree of adoption in cases where the adopted child, before reaching the age of 14, develops feebleminded-ness, epilepsy, insanity or venereal disease. Died in committee.

Successful Cleveland TV Programs To Be Continued in Fall

Between January and May, 1953, Cleveland Health Museum and the Academy of Medicine of Cleveland presented 16 one-half hour television "Prescription for Living" shows sponsored by Standard Oil Company of Ohio. They attained an average 12.2 T.V. rating, indicating an average audience of something over 218,000 sets, not less than 500,000 viewers. Originating in Cleveland, it was carried by an Ohio-wide network.

The presentation was above the well meaning but non-professional standards often seen on this type of show. It was produced by the television department of McCann-Erickson, Inc., Cleveland, and written by Storycraft, Inc., to utilize a "typical" Ohio family (professional actors) whose lack of understanding of medical practices made it a foil for the guest physician from the Academy of Medicine. Each show handled one subject. The scene shifted from a common fallacy to facts from physicians. Health Museum exhibits were used as visual aids. The cost of production ranged between $1,500 and $2,000 per show.

The offer of free digests of each show drew mail requests as high as 2,100 for "Shorter Waistline —Longer Lifeline." The average number was under 1,000. Sample digests sent to teachers of Cleveland public schools brought personal requests from 3,200 teachers to receive the digests weekly. Other school systems also requested them.

The heavy correspondence handled by the Health Museum as a result of the show was on a high level; hardly any crank letters were received.

The television show "Prescription for Living" will be resumed in September for 26 weeks. Limited numbers of digests of the first series are available from the Cleveland Health Museum, 8911 Euclid Avenue, Cleveland 6, Ohio.

The James Picker Foundation, Inc., Hanover Bank Trustee, 70 Broadway, New York 4, is making available grants for research in the field of diagnostic x-ray by mature investigators.

A. M. A. Council on Medical Education And Hospitals Gets New Secretary

The Board of Trustees of the American Medical Association has announced the appointment of Dr. Edward L. Turner, 52, dean of the School of Medicine at the University of Washington in Seattle since 1945, as secretary of the A. M. A. Council on Medical Education and Hospitals.

Dr. Turner, who will take over his new duties October 1, succeeds Dr. Donald G. Anderson, secretary of the council since 1947, who has been appointed dean of the University of Rochester School of Medicine.

In addition to serving as dean of the medical school at the University of Washington, Dr. Turner also was chairman of the Division of Health Sciences at the university, which includes the schools of medicine, dentistry, nursing and pharmacy.

The Board of Trustees also announced the appointment of Dr. Edward H. Leveroos, who has been an associate secretary of the Council on Medical Education and Hospitals, to a newly created position—director of the Division of Hospitals and Graduate Education of the council.

In this new position, Dr. Leveroos will be in direct charge of the council's program of approving hospitals for internship and residency training and of the activities of the council's staff in the program of the Joint Commission on the Accreditation of Hospitals.

Dr. Francis R. Manlove, an associate secretary of the council, has accepted a position as director of the medical center of the University of Colorado at Denver, succeeding Dr. Ward Darley, who has been made president of the university. Dr. Manlove, who has been with the council for three years, will take up his new duties November 1.

Top Honor in National Medical Stamp Exhibit Goes To Dr. Bruner

Dr. A. B. Bruner, Cleveland, won a gold cup and certificate as first prize award in the Third National Medical Stamp Exhibit sponsored July 11-27 jointly by the Cleveland Health Museum and the Garfield-Perry Stamp Club of Cleveland.

Dr. Maurice J. Strauss and Dr. C. H. Hitchins, both of New Haven, Conn., received second and third place award certificates, respectively. Honorable mention went to Mrs. R. G. Leggett, Houston, Texas, a patient bedridden for years with arthritis who remarked, "Stamp collecting is my greatest therapy."

Stamp categories included medicine and surgery, medical schools and laboratories, medical congresses, U. S. commemorative medical portraits, public health, drugs, Red Cross, disaster and relief, cancer, tuberculosis, nurses and child welfare.

Additional Grant Made for Heart Study at O. S. U.

The American Heart Association in conjunction with its affiliate, the Central Ohio Heart Association, has allocated $5,250 as a research grant-in-aid to Dr. Leo A. Sapirstein, of the Ohio State University College of Medicine. He is investigating the composition of body fluids and their changes in the presence of high blood pressure.

The American Heart Association marked its fifth anniversary by awarding an additional $473,930 for 89 research grants—bringing the total to almost six and a half million dollars for research.

The Central Ohio Heart Association this year allocated $56,621.55 for research grants. It is estimated that research awards by affiliated heart associations and their chapters during the 1952-53 fiscal year totaled approximately $1,250,000. This sum, together with the $810,830.59 allocated in the joint national program, makes a combined total of over two million dollars appropriated for cardiovascular research in the 1952-1953 fiscal year by the American Heart Association and its affiliates.

Dr. Evans of Columbus Named President Of National Ass'n of Coroners

Dr. Robert A. Evans, Columbus, Franklin County coroner, was elected president of the National Association of Coroners, which met in Columbus, August 3-6.

Other Ohioans elected to office in the national group were Dr. Herbert P. Lyle, Cincinnati, second vice-president; and Dr. Samuel R. Gerber, Cleveland, executive secretary and treasurer.

Ohioans appointed to the Board of Directors were Drs. David A. Belinky, Youngstown; G. Paul Hohly, Toledo; and Layman A. Adair, Wooster.

Among new officers of the Ohio Association of Coroners are: Drs. J. Martin Byers, Highland County (now serving with the Army), vice-president; David A. Belinky, Youngstown, treasurer; Samuel R. Gerber, Cleveland, secretary; D. J. Slosser, Defiance County, chairman of the board of trustees. Among board members are Drs. Herbert P. Lyle, Cincinnati; G. Paul Hohly, Toledo; Lyman A. Adair, Wooster and Michael E. Cristo, Trumbull County.

Today's Health Takes Two Awards

The magazine, *Today's Health*, published monthly by the American Medical Association, recently won two awards for "excellence of design" in the annual show of the Society of Typographic Artists at the Art Institute in Chicago.

Occupational Skin Problems To Be Subject of Course

The Institute of Industrial Health of the University of Cincinnati announces a course of instruction in Occupational Skin Problems to be presented jointly by the Division of Occupational Health of the Public Health Service, the Department of Preventive Medicine and Industrial Health, and the Department of Dermatology and Syphilology of the University of Cincinnati. It will be given during the week of October 12-16, 1953. The objective of this course is to give physicians a greater understanding of cutaneous problems of occupational origin.

Physicians interested in attending the course should write for application blank to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Aves., Cincinnati 19, Ohio. A registration fee will be charged and early application is advised since attendance will be limited.

Dr. Wiseley Heads Scientific Council Of Central Ohio Heart Ass'n

Dr. Frank Wiseley, of Findlay, was elected president of the Scientific Council of the Central Ohio Heart Association at its last meeting at Children's Hospital in Columbus. Other officers for the coming year will be: Dr. Walter Heine, Circleville, first vice-president; Dr. Edgar Northrup, Marietta, second vice-president; and Dr. Donald Mahanna, Columbus, secretary.

Soil and Food in Good Living To Be Discussed by Dr. Forman

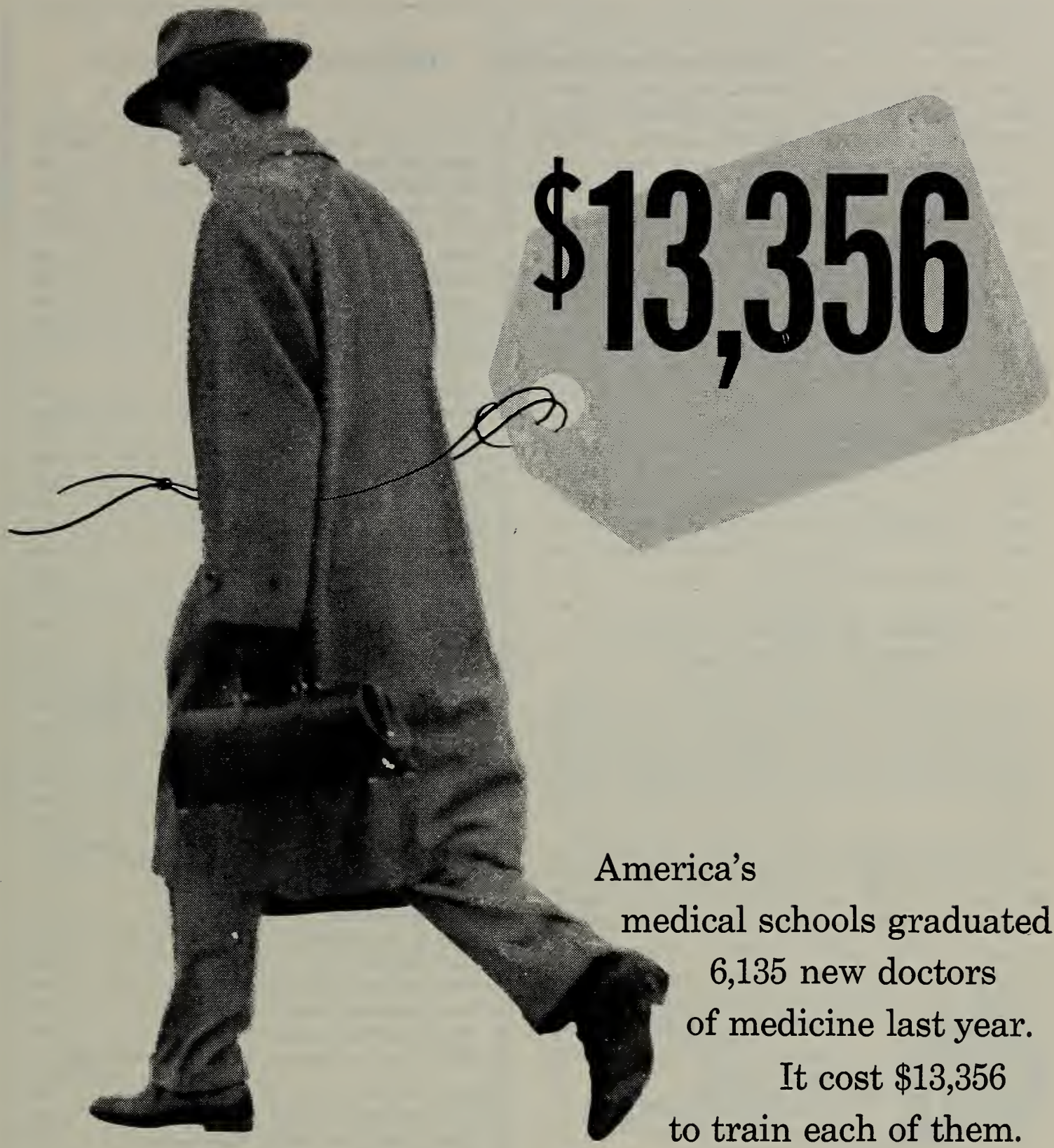
Dr. Jonathan Forman, Editor of *The Journal*, will be one of the principal speakers in the conference on "Getting the Most Out of Life," to be held in the East Bay Camp, Bloomington, Ill., September 4-7. His subject will be "What Do Soil and Food Mean to Good Living?"

The conference is sponsored by The School of Living of America, an organization dedicated to the education and re-education of the public toward normal living.

Cincinnati Physician Helps Establish Israeli Psychiatry Department

Dr. Milton Rosenbaum, professor of psychiatry at the University of Cincinnati College of Medicine, is spending several months as the first visiting professor of psychiatry at the Hebrew University-Hadassah Medical School in Jerusalem, where he is helping to establish a new department of psychiatry.

Dr. Rosenbaum recently has been appointed head of the new Department of Psychiatry at Cincinnati Jewish Hospital.



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biology; Charles H. Herndon, associate professor of orthopedic surgery; David R. Weir and Austin S. Weisberger, associate professors of medicine; Alfred A. K. Bochner, assistant professor of psychiatry; George H. A. Clowes, assistant professor of surgery, and William McD. Jeffries, assistant professor of medicine.

Drs. William S. Jordan, Jr., is assistant professor of medicine and preventive medicine and Jon L. Karlsson in microbiology; Charles N. Loeser in anatomy; Harry Rudney and Leonard T. Skeggs in biochemistry; Robert F. Williams in medicine.

Drs. Roscoe D. Leas becomes associate clinical professor of medicine, Gerard A. DeOreo, assistant clinical professor in dermatology. Drs. Joseph I. Goodman, Charles L. Hudson and Gerald T. Kent are assistant clinical professors in medicine. Drs. York N. Pitkin, Herman K. Hellerstein, Frank J. Rack, Jack W. Cole, Herome Kleinerman, Arthur J. Newman, Lionel A. Manson, James W. Craig, Henry F. Saunders, Harvey C. Janke and John J. Stewart, also step up in rank.

Number of Births in Nation Still on the Increase

The national birth total continued to rise during the first three months of 1953, after setting a new annual record of 3,889,000 registered and unregistered births in 1952, according to vital statistics estimates released by the Public Health Service.

Births during the first quarter of 1953 were running about 29,000 ahead of the same period last year, an increase of three per cent. March was the tenth consecutive month in which the estimated total births topped corresponding monthly figures for the previous year.

The level of births for the first three months is at an annual rate of 25 live births per 1,000 population. This is slightly higher than the birth rate for the first quarter of 1952.

Study Shows Who Pays Hospital Bills

The Connecticut Hospital Association recently completed an interesting and significant study.

It analyzed cases and patient days in the 34 general hospitals in the state for the year ending September 30, 1952, and learned that:

Only 15 per cent of patient days in Connecticut's community hospitals were paid for by the patients.

Connecticut's Hospital Service (Blue Cross) absorbed the costs of 50 per cent of cases and 45.5 per cent of patient days.

Commercial insurance carriers paid 24.5 per cent of total hospital charges in both categories.

City and town welfare budgets were called on to meet costs for only 1.5 per cent of cases and 2.5 per cent of patient days.

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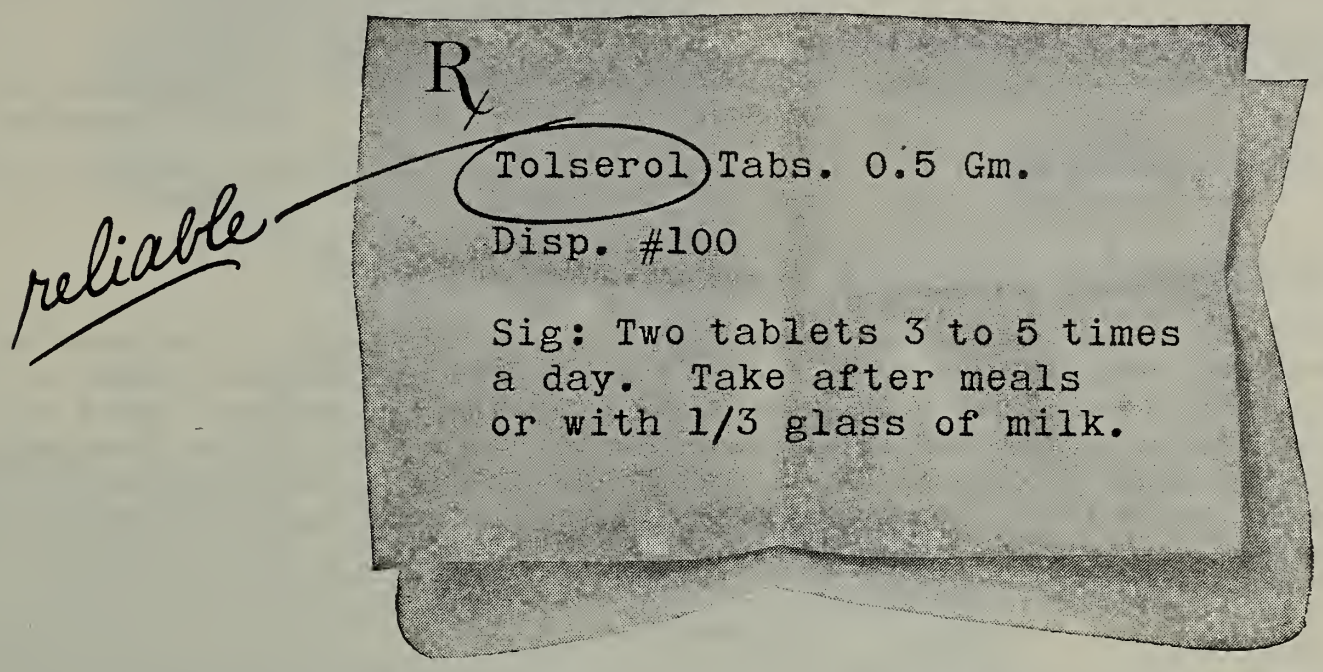
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operative

schedule

8:00 A.M.	Amphitheatre	Cholecystectomy
8:00 A.M.	Room B	Thyroidectomy
8:15 A.M.	Room C	Radical Mastectomy
8:45 A.M.	Room A2	Submucous Resection
9:30 A.M.	Amphitheatre	Resection of Ileum

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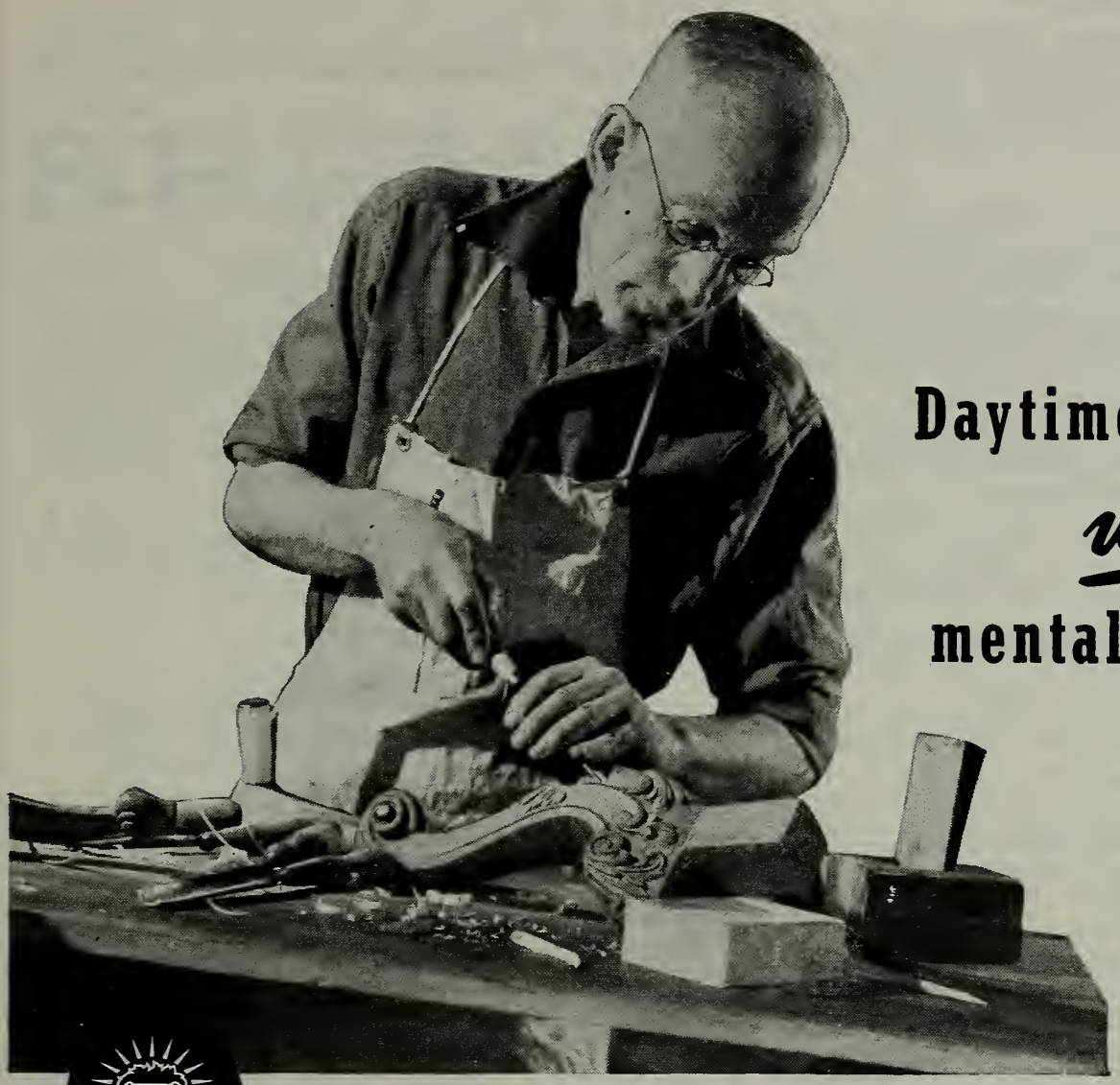
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Sociology Applied to Nursing, by Emory S. Bogardus, Ph. D., and Alice B. Brethorst, Ph. D., R. N., ($3.50. 3rd Edition. *W. B. Saunders, Company, Philadelphia 5, Pa.),* covers the field giving special attention to the latest developments in nursing problems wherever any sociologic significance is involved, and to new social facts and drugs as they affect nursing.

When You Date, by Esther Eby Glass, (35¢. *Mennonite Publishing House, Scottdale, Pa.).* This strictly American institution is discussed in the spirit of the Christian spirit of the Mennonite brethren.

Clear Thinking About Courtship, by John C. Wenger, (30¢. *Mennonite Publishing House, Scottdale, Pa.).* Excellently done in an effort to make youth see that the selection of a life companion and laying of a strong foundation for a successful marriage are not matters of mere emotion. They are decisions calling for careful thinking.

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Living Happily Married, by John R. Mumaw, (35¢. *Mennonite Publishing House, Scottdale, Pa.),* gives the best of Christian advice to the newlyweds as they go about the task of building a successful married life.

Becoming Parents, by H. Clair Amstutz, M. D., (50¢. *Mennonite Publishing House, Scottdale, Pa.),* presents a wholesome viewpoint of the responsibilities of parenthood. Prepared for Mennonites.

Christian Family Living—A Selected Book List compiled by Alta Mae Erb, (Apply. *Mennonite Publishing House, Scottdale, Pa.).* Some 33 pages of books on all phases selected by the assistant secretary of Home Interest. This series, in the mind of your reviewer, is an excellent set of pamphlets to put in the hands of teenagers, engaged couples, newlyweds and new parents.

Textbook of Physiology, by William D. Zoethout, Ph. D., and W. W. Tuttle, Ph. D., ($4.75. 11th Edition. *C. V. Mosby Company, St. Louis 3, Mo.).* Several chapters have been entirely rewritten and great emphasis has been on dynamic equilibrium. In tune with current needs, the newer conception of the functions of the prefrontal and orbitofrontal areas in relation to psychosomatic reaction has been noted.

Health Instruction Yearbook—1952, by Oliver E. Byrd, M. D., ($3.50. *Stanford University Press, Stanford University, Stanford, Calif.).* The Professor of Health Education at Stanford University, as has been his custom for several years, read some 1500 articles in professional health journals and selected 273 to condense as a reflection of public thinking on Health and Disease.

Diuretic Therapy, by Alfred Vogl, M. D., ($5.00. *Williams & Wilkins Co., Baltimore, Md.),* is essentially an up-to-date manual on the management of the edematous patient. In the 175 years since digitalis was introduced as a remedy for heart failure and its attendant edema, the treatment of congestive heart failure with organic mercurials, originating from the author's observations, is undoubtedly one of the great triumphs of modern medicine. This manual with its wealth of pharmacologic and clinical information and advice deserves a wide sale and certainly a place in every house-staff library.

Clinical Cardiology, edited by Franklin C. Massy, M. D., with 33 collaborators. ($13.50. 250 illustrations. *Williams & Wilkins, Baltimore 2, Md.).* Here experts in their selected fields combine their efforts to produce a well-balanced, informative work designed especially for the graduate physician. In this way those who designed and edited the book, have tried to inform us of the part that the newer knowledge of the heart plays in our own specialty (no matter what it may be); to close the gap between experimental results and clinical application; to include the controversial material as well as the established facts so that the physician interested in the heart may judge for himself at least the trend of knowledge in this field.

A Manual of Clinical Allergy. by John M. Sheldon, M. D., Robert G. Lovell, M. D., and Kenneth P. Matthews, M.D., ($8.50. *W. B. Saunders Company, Philadelphia 5, Pa.),* comes from the staff of the division of allergy at the University of Michigan. It is the practical informative discussion we have been led to expect from Dr. Sheldon. It is intended to stimulate each of us to give our allergy patients (and 10 per cent of any practice are allergy patients) the thorough management which they deserve. If any doctor of medicine will read this book he will be

able to serve his patients better and cut down on his failures very appreciably.

Synopsis of Pathology, by W. A. D. Anderson, M. D., (\$8.00. 3rd Edition. *C. V. Mosby Co., St. Louis 3, Mo.)*, is a complete revision of a comprehensive but concise presentation of pathology. It therefore succeeds in filling the gap between the outlines and volumes of reference.

Women are My Problem, by Jacob L. Bubis, M. D., (\$3.00. *Comet Press Books, New York 36, N. Y.)*, is the autobiography of the well known Cleveland specialist. It contains an historical picture of the old Mt. Sinai, Lakeside, and the new Mt. Sinai Hospitals as well as much material on the growth of medicine and medical Cleveland by an on-the-spot observer.

Look in Your Mirror—A Study in Human Behavior, by John Potts, M. D., (\$3.00. *Vantage Press, 230 West 41st St., New York 36, N. Y.)*, is designed to help us see ourselves as in a mirror and thus to understand and change our behavior by relieving ourselves of bad emotions.

Neurosurgery in General Practice, by Adrien Ver Brugghen, M. D., (\$14.00. *C. C. Thomas, Publisher, Springfield, Ill.)*, designed to tell those of us who are not specialists in this field how to decide whether a patient has a neurosurgical problem and how to make an early disposition of a neurosurgical case. Clear, concise pictures are drawn of what we should know about the subject. It is not a book for neurosurgeons but a book for the rest of us physicians.

The Science of Biology, by William C. Beaver, Ph. D., (\$5.85. 4th Edition. *C. V. Mosby Company, St. Louis 3, Mo.)*. This standard text by the professor at Wittenberg College has undergone another thorough revision. It will do most of us older physicians good to spend some of our long winter evenings with the text while the family views television.

A Textbook of Pathology, by E. T. Bell, M. D., B. J. Clawson, M. D., and J. S. McCartney, M. D., (\$12.00. Seventh Edition. *Lea & Febiger, 600 S. Washington Square, Philadelphia 6, Pa.)*. When your reviewer was a young assistant professor of pathology, there were only two American texts. Each generation of medical students has seen an increasing number of its own instructors presenting their own texts as a part of the instruction. There are many advantages to supplementing the lectures and laboratory work with one's own reference text. For some time now the course in pathology at the University of Minnesota under Dr. Bell has been outstanding and his text has improved with each edition. This, the seventh, should be a work of reference in every departmental and intern library.

Child Psychology—Summary of Growth and Development with Review Questions and Answers, by Lester D. Crow and Alice Crow, (\$1.50. *Barnes & Noble, Inc., 105 Fifth Ave., New York 3, N. Y.)*. All the essentials of child psychology are completely covered and carefully condensed in this new book in the College Outline Series. It is up-to-date in every respect—recent research and ideas in child growth are included. The various schools of thought concerning individual growth and development are all presented. Professors, students, parents, and all others who work with children will like its simple statements of scientific fundamentals.

Sterility—The Diagnostic Survey of The Infertile Couple, by Walter W. Williams, M. D., (\$12.75. *Published by the Author, 20 Magnolia Terrace, Springfield, Mass.)*. First off, your reviewer has been begging persons and individuals who were opposing birth control to do something for the childless couple. The author of this work has been doing just that. He has been engaged in the study of sterility since 1915.

Another thing we like about the man and his book: His application of his systematic study of the possible causes of sterility in a married couple has demonstrated its practical character in his own private practice financed itself without any aid or grants. There is much research that can best be done under exactly those circumstances. It is just too bad that no one seems to think of it—least of all, we teachers of medical students.

The book itself is a manual for the solution of the problems of infertility. As such, it should be in the hands of every gynecologist, in fact every physician who dares to give advice on such matters. Your reviewer urges that it also be placed in every interns' library in the hope that it might inspire young men to prepare themselves in this field. Nothing is more tragic than to be denied a family when one is wanted.

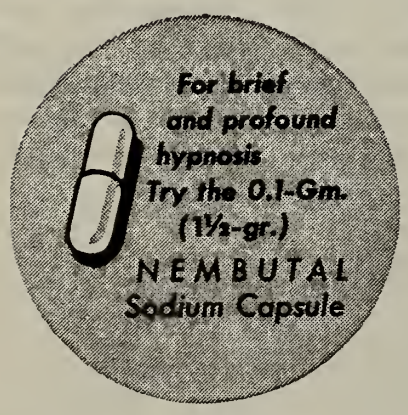
Handbook on VD, by Carroll T. Bowen, M. D., (\$1.25. *University of Miami Press, Coral Gables 46, Florida)*, records the gist of the excellent talks which the author gave to high school students in south Florida. This distinguished authority and successful health officer has played a major role in changing south Florida from one of the highest VD rates to one of the lowest. This book does not deal with sex education but the desperate matter of health education.

Surgery of The Eye, by Meyer Wiener, M. D., and Harold G. Scheie, M. D., (\$15.00. Third Revised Edition. *Grune & Stratton, Inc., New York 16, N. Y.)*. While the general outline and purpose of this text have not been changed, a number of new operative procedures have been added. The entire first half of the book has been entirely re-written. This text will continue to be one of the useful ones as it has for the past fourteen years.



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Joint Stabilization Through Induced Ligament Sclerosis

GEORGE S. HACKETT, M. D.

THIS article is presented following a series of 253 cases of sacroiliac relaxation which have been treated during the past 14 years.

It is the author's opinion that the sacroiliac articulation is an important factor in low-back pain and disability, a factor which has been almost eliminated from consideration in the past two decades. It is, furthermore, the author's opinion that the most frequent factor in chronic or recurrent sacroiliac disability is relaxation of the posterior sacroiliac ligament.

A simplified, specific method of diagnosis of this condition will be presented and a method of treatment by ligament sclerosis will be described which has been found to be very successful.

The Author

● **Dr. Hackett, Canton, Ohio, is consulting surgeon at Mercy Hospital.**

HISTORICAL REVIEW

Mengert[1] in 1943 pointed out that relaxation of the ligaments results in instability of the joint and increased susceptibility to strain and sprain. This had been pointed out with reference to the pelvic ligaments in 1911 by Meisenbach and in 1916 by Magnuson.

In 1927 when Gaenslen described his diagnostic sign for sacroiliac disability he pointed out that it depended upon "impaired ligamentous support." He then went on to describe his arthrodesis which had the advantage "that the posterior sacroiliac ligaments were not weakened or interfered with."

In 1944 Ghormley observed, "As the widespread interest in lesions of the intervertebral discs has drawn increased attention to the lumbosacral joint the importance of the sacroiliac joint as a source of symptoms has waned, perhaps to a point where sacroiliac conditions may be overlooked."

Again in 1951 Ghormley stated that since the syndrome of the intervertebral disc has been recognized perhaps the diagnosis of sacroiliac strain "should not have been abandoned for undoubtedly the sacroiliac joint does cause symptoms at times."

A survey of the literature shows that although the preponderance of sacroiliac disability was recognized to be a result of impaired ligamentous support, the treatment whether by operation or mechanical support has had a tendency to weaken the ligaments.

It would further appear that this is the first successful method of strengthening the ligamentous support of the pelvis. Re-establishment of the tension of the ligaments stabilizes the joint and eliminates the pain and susceptibility to recurrence. The stabilization is accomplished through sclerosis of the ligaments and is achieved by the injection of a sclerosing solution within the fibrous bundles of the ligament.

HISTORY OF SCLEROTHERAPY

A review of the history of sclerotherapy (treatment by injection of a sclerosing solution) since its introduction in 1832 has been given by Riddle.[2] A scientific rationale for sclerotherapy was established in 1881 when Warren reported a study of tissue reaction to the injection

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Read before the Stark County Medical Society, April 9, 1953.

of *Quercus alba*. This reaction was characterized by the early formation of "plasto-lymph"; this later became organized into fibrous tissue which acquired strength in 10 to 12 days.

In 1929 Hall and Frasier, using guinea pigs, monkeys, and dogs, demonstrated the vigorous proliferation of endothelial and connective-tissue cells following the injection of a sclerosing solution. These experiments were verified and elaborated by Harris, Manoil, White and Biskind, and others who compared the effects of different solutions. Harris and his associates, using guinea pigs, showed that the main mass of proliferating fibrous tissue was located in the connective-tissue septa.

Rice[3] also investigated human tendons and fascia and observed the progressive effect of various solutions on the tissues at periods ranging from 15 hours to 42 days. He observed that the tissue reaction induced by irritants follows the pattern of inflammation. The reaction of connective-tissue cells is one of permanence and contractility. This investigation also revealed that the ideal solution was one which produced a minimum of early exudate and later a maximum of connective tissue. Investigation is being made on the histological effects of sclerosing solution injected into the ligaments of animals. They appear to complement the results previously mentioned and will be reported on completion.

Sclerotherapy is successfully used today in hospitals and university clinics by many competent surgeons in the treatment of varicose veins, hemorrhoids, hernias, hydroceles, bursae, ganglions, and angiomata; it is also used within the joint cavity for the treatment of relaxation of the temporomandibular and other small joints.

No mention has been found in the literature of sclerotherapy within the ligaments. However, in 1930, following anatomical studies which revealed the richness of sensory nerve endings in articular ligaments, Leriche advocated the infiltration of these ligaments with procaine for the relief of pain in functional articular disturbances after sprains or fractures.

I wish to emphasize the specific points in the differential diagnosis of sacroiliac relaxation and submit a method of treatment which I have found to be successful in this disability as well as in some other situations where relaxation of the joints exists.

ANATOMY

"The pelvic arch is formed by the sacrum and the two iliac bones . . . the sacrum is not held in place by virtue of its position or form, but is suspended from the iliac bones by a very strong posterior sacroiliac ligament in such a way that they bear all the strain, the bone shape contributing no support whatsoever," according to Eliason. The size of the posterior sacroiliac ligament indicates its importance in supporting the articulation and in preventing any excess movement of the articulation (Figs. 1 and 2).

The center of the sacroiliac joint lies immediately in front of the posterior superior spine of the ilium. The posterior sacroiliac ligament forms the chief bond of connection between the sacrum and the ilium. It fans out posteriorly and medially from the posterior margin of the sacroiliac joint. It is attached medially to the spines and body of the first, second and third segments of the sacrum. The lateral attachment of the ligament is to that portion of the wing of the ilium which extends to the sacroiliac joint.

Francis[4] recently pointed out that the sacroiliac joint may be classified as a gliding joint rather than a hinge joint. He also presented a more detailed description of the pelvic ligaments. "The interosseous sacroiliac ligament, which

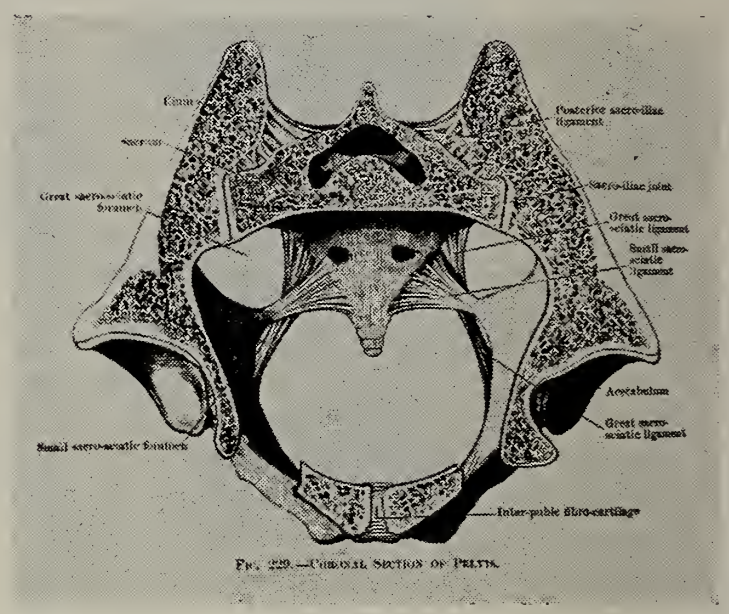


Fig. 229.—Coronal Section of Pelvis.

Fig. 1

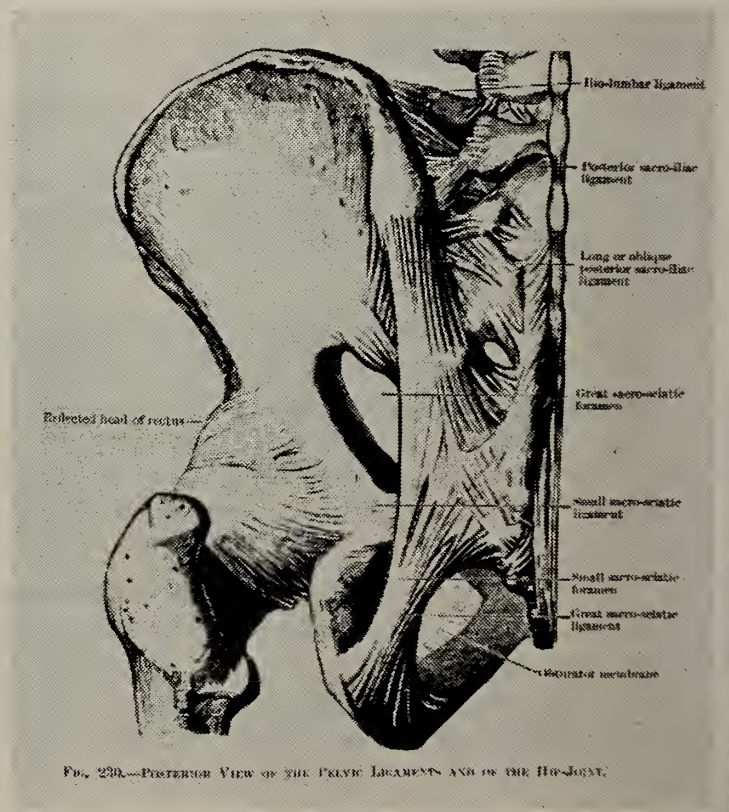


Fig. 232.—Posterior View of the Pelvic Ligaments and of the Hip-Joint.

Fig. 2

may be regarded as the deepest portion of the general posterior ligament, consists of many very strong fibers which pass in various directions between the iliac and sacral tuberosities . . . . the interosseous and posterior sacroiliac ligaments prevent forward movement of the sacrum in weight bearing . . . ." Since the fibers run in various directions, the ligament lends itself particularly well to stabilization by sclerosis.

ETIOLOGY

Functional relaxation of the posterior sacroiliac ligament occurs during pregnancy. Francis[4] states that "During pregnancy the corpus luteum elaborates a hormone called relaxin. The exact method of its action in human beings has not been determined, but during pregnancy the ligaments relax permitting the sacroiliac joints and the pubic symphysis to become wider and allowing a greater range of movement. After delivery the joints gradually return to practically their original condition. The relaxation of the sacroiliac joints, together with the forward shift of the center of gravity that occurs during pregnancy, account for much of the low backache and for the signs of sacroiliac strain frequently observed in the late months of pregnancy."

Sometimes after parturition the ligaments do not regain their previous tension and the relaxation persists, resulting in chronic low-back pain and susceptibility to strains.

Pathological relaxation of the posterior sacroiliac ligament results from strains, sprains, and tearing of the fibers, which may occur in two ways (see Cases 4 and 14 below):

1. Through a single, specific trauma incidental to the strain of an unaccustomed task. This may occur in a person of sedentary occupation carrying a heavy object, such as the executive carrying a piano, in Case 3, or in anyone receiving a sudden jerk while lifting or carrying a heavy object. Moreover, an increasing number of cases of sacroiliac relaxation may be seen as the result of the growing number of automobile rear-end collisions. The victim may be in either car, either as the driver or as a passenger. (See Case 16.)

2. As the result of an occupation which requires a great deal of lifting, twisting strain in a stooped position, such as that of a housewife, farmer, an athlete, or an industrial worker. (Note case reports.)

PATHOLOGY

Anderson and Peterson[5] in 1944, using the Chamberlain roentgenographic technique, verified abnormal movement in the sacroiliac joint which has been mentioned by Snelling in 1870 and demonstrated by Goldthwaite and Osgood in 1905.

"Relaxation of these ligaments favors a forward displacement of the top of the sacrum, although the resultant subluxation is so slight that rarely is it recognizable on the roentgen ray plate," according to Lynch.

It is the author's contention that when abnormal movement develops in a joint, this is due to a relaxation of the ligaments and is frequently accompanied by pain. It is this condition which will here be referred to as "relaxation of the posterior sacroiliac ligament."

DIAGNOSIS

SYMPTOMS

1. The pain accompanying relaxation of the sacroiliac ligament may be continuous or recurrent and is susceptible to acute aggravation. It may be aching in character, or it may be severe and knifelike when movement is attempted and prevent all movement. It is aggravated by bending, twisting, rising and sitting, coughing, sneezing, or prolonged arduous activity. In the severe cases, the pain and inability to turn is so marked that the patient is not only unable to perform any labor, but is often confined to bed. The general activity of the patient is usually curtailed.

Many patients endure the pain for years, learning to live within the restrictions of their back, seeking relief only when it becomes unbearable. This is especially true if it first appears during the discomforts of pregnancy, or when the patient assumes it to be the result of a fracture of the spine, pelvis, or femur, or when its origin is complicated by some other factor.

2. Important is the fact that sacroiliac pain is unilateral and often confined to the buttock. If the pain is referred beyond the buttock, it usually goes down the outside of the thigh as pointed out by Baer in 1917 and later by J. Travell and W. Travell.[6] Occasionally it goes below the knee, usually coursing down the lateral aspect of the leg along the peroneal region to within two inches of the tip of the external malleolus. It does not extend to the foot. Rarely if ever is the pain referred down the back of the thigh or to the calf, and the sciatic nerve is never tender on pressure or painful on stretching.

Frequently the irritation of the needle, as described by J. Travell[6] and W. Travell,[6] Steindler, and Steinbrocker, and the pressure of the anesthetic within the posterior sacroiliac ligament will immediately reproduce the local pain as well as the referred pain low in the buttock laterally and occasionally down the outside of the thigh and leg; this will last for about two minutes until anesthesia begins. In over 1000 injections performed by the author, the pain never went down the back of the thigh or down the calf or into the foot.

The use of efocaine® will reproduce the referred pain with greater intensity for two minutes because of the immediate local reaction which it produces.

Pain is occasionally referred into the groin but this pain disappears when the sacroiliac

relaxation is relieved. The pain in the groin has never been reproduced by the insertion of the needle.

3. One cannot rule out bilateral sacroiliac disability when there is a history of pain in both buttocks. Sometimes the patient will call attention to symptoms referable to the opposite joint after the acute phase has cleared up on the first side. When bilateral sacroiliac relaxation exists, the patient may suffer an acute exacerbation at one time on one side and at another time on the other side. These cases call for careful diagnosis; they do respond to treatment.

4. In very severe cases activity is curtailed and strong analgesics, such as codeine or demerol,® are necessary for relief. Only a small percentage of the patients have to be hospitalized.

EXAMINATION

In the diagnosis of low-back disabilities, these points are important in the following order: (1) The patient should by his own movements produce the "trigger point" of pain and locate it with **one** finger. (2) The examiner should locate the trigger point with **one thumb.** This is more readily accomplished while the patient is making strain on the ligament. (3) The examiner should then confirm the trigger point by eliminating it with the injection of a local anesthetic.

1. When standing erect the patient often locates the pain in the sacroiliac area. Frequently bending, twisting, and lifting are necessary to aid in its definite location. It has been the author's observation that frequently the patient will be able to locate the trigger point in the posterior sacroiliac ligament with **one** finger when the spine is in extreme hyperextension rather than flexion. The patient's finger is frequently placed lateral to the posterior superior spine because the joint is located beneath and lateral to the spine.

AUTHOR'S TEST

2. The following test has been developed by the author: The patient stands with feet together, knees extended, body bent well forward, and arms hanging free. The examiner stands behind and somewhat to the left of the patient. The examiner's left hand is placed in front of the pelvis and gently grasps the area in the region of either anterior superior spine of the ilium, or he may gently grasp the patient's left shoulder with his left hand. The right thumb is placed in the sacroiliac groove (the depression between the posterior superior spine of the ilium and the sacrum) and gentle but firm pressure is made with the thumb as the patient assumes the erect position. The patient will flinch and tell the examiner "that is the place" if the sacroiliac joint is involved. The examiner should then compare this with the other sacroiliac joint, with the lumbosacral depression, and again with the suspected side. This is the most valuable of all tests, because it is almost always positive when the sacroiliac joint is involved; it is so easy to make that any physician could become adept at performing it.

3. The examiner should be able to determine whether both sacroiliac joints are involved.

The examiner can usually determine whether the superior or the inferior portion of the ligament is more involved by pressing with his thumb above and again below the posterior superior spine of the ilium as the patient assumes the erect position.

4. Have the patient lie in the supine position. Steindler and Luck pointed out that the leg tests cause strain in so many structures; "the identification of the particular structure involved rests with the local point of tenderness." Gaenslen's sign, Lasègue's sign, fabere sign, and the Pitkin maneuver are frequently positive for pain in the sacroiliac area, and when present they confirm the test described above. When pain is produced by any of these tests the patient should place **one finger** on the trigger point, and the examiner should check the point with his finger in order to determine which pelvic joint is involved.

CONFIRMATION OF DIAGNOSIS

5. To confirm the diagnosis the patient should lie in the prone position, comfortable and relaxed. With a 24-gauge needle 1½ inches long, or a 23-gauge needle 2½ inches long (depending on the size of the patient), five to ten cubic centimeters of a local anesthetic solution is injected mid-way between the midline and the posterior superior spine of the ilium, the needle being inserted through the skin and directed outward at an angle of 45 degrees beneath the ilium. Figure 1 illustrates the accessibility of the posterior sacroiliac ligament for insertion of the needle, both in diagnosis and treatment. The resistance of the ligament will be felt. The anesthetic is injected ahead of the needle fanwise in three directions until the hub of the needle depresses the skin.

The operator's touch should be so delicate and experienced and the insertion of the needle so gentle that he will know when the point of the needle is entering the ligament or impinging on either the ilium or the sacrum before the patient detects it. If necessary the needle should be withdrawn enough to change its direction. After a few minutes the patient arises and is able to go through movements without pain which were not possible before.

Haldeman in 1938 described this method for differential diagnosis.

COMPLICATIONS IN DIAGNOSIS

Frequently, after an accident or during an acute exacerbation, the diagnosis cannot be definitely made for several days or a few weeks

until the pain and tenderness have subsided and become localized under treatment by rest, belt support, analgesics, and sedatives. The ice bag will usually give more relief than heat. Diathermy and lamps are of no special benefit.

Relaxation of the ligament frequently results from an accident in which the pelvis, spine, or femur is fractured. In these cases the sacroiliac condition may go unnoticed until after a few months, when the fractures have united and the patient resumes his activities, causing distress in the weakened sacroiliac joint (cases 7, 8, 15, 16). All patients with confining injuries between the chest and the knee should be examined for low-back injury after activity has been resumed and before discharge.

Frequently two or more low-back disabilities co-exist, and it is necessary to recognize them. The presence of each should be fully explained, so that the patient will understand what to expect. Otherwise, the treatment will be unsatisfactory to both the patient and the doctor. This is particularly true when relaxation of the posterior sacroiliac ligament co-exists with either relaxation of the lumbosacral ligaments, disc injury, or arthritis of the lumbar spine accompanied by pain.

ROENTGENOLOGY

Although roentgenograms should always be made, they are usually without value in cases of relaxation of the posterior sacroiliac ligament. Roentgenographic evidence of hypertrophic arthritis does not necessarily signify that the arthritis is the cause of the low-back pain. Frequently sacroiliac relaxation has been relieved by sclerosis when arthritis of the sacroiliac joint was also present (Case 17).

DIFFERENTIAL DIAGNOSIS

1. Pain and point of tenderness are localized just beneath the posterior superior spine of the ilium.
2. The pain is unilateral and when referred goes laterally into the buttock and down the outside of the thigh, occasionally extending into the lateral side of the leg but never into the foot.
3. The sciatic nerve is never tender or painful on stretching, but pain may occasionally go down the back of the calf.
4. The patellar and Achilles reflexes are not affected.
5. When the patient is standing erect, moderate flexion of the spine frequently is not painful; extreme hyperextension frequently is painful.
6. When present, deviation of the spine is to the uninvolved side.
7. When the patient is standing with the body bent forward, pressure in the sacroiliac groove with the thumb as he straightens up will always produce definite pain, as compared with the opposite sacroiliac and lumbosacral articulations.
8. Gaenslen's sign, Lasegue's sign, fabere sign and the Pitkin maneuver are frequently positive.
9. Injection of a local anesthetic within the ligament will relieve the pain and confirm the diagnosis.
10. Roentgenograms are not of positive value.
11. A man's belt worn tightly beneath the anterior superior spines of the ilium will frequently relieve sacroiliac pain but no other low-back pain.

TREATMENT

Relaxation of the sacroiliac joint is particularly adaptable to stabilization by sclerotherapy since the fibers of the posterior sacroiliac ligament pass in various directions (Figs. 1 and 2) and the proliferation of fibrous tissue which takes place in the connective-tissue septa between the separate bundles and fibers of the ligament will both strengthen the ligament and inhibit the abnormal movement in the joint. Excellent results have been obtained, and in over 1,000 injections no infection, hematoma, sloughing, paralysis, paraesthesia or any other detrimental result has occurred.

TECHNIQUE

The patient lies relaxed on the abdomen. The site selected for injection may be beneath the posterior superior spine of the ilium or within 1½ inches above or below.

A 24-gauge needle 1½ inches long or a 23-gauge needle 2½ inches long attached to a syringe containing three to five cubic centimeters of long-lasting local anesthetic is inserted through the skin at a point one-half inch lateral to the mid-line at an angle of 45 degrees. The anesthetic is slowly injected ahead of the needle until the needle has been inserted its full length and its hub is depressing the skin.

While the needle remains in place the syringe is replaced by one containing one-half to one cubic centimeter of the sclerosing solution which is then injected into the ligament, not into the muscle or subcutaneous tissue, as the needle is withdrawn. The posterior margin of the sacroiliac articulation is approximately three inches in length, and the posterior sacroiliac ligament fans out to perhaps four inches. The relaxation and pain usually occur in the upper portion of the ligament where the fibers are longer, and more injections are required above the posterior spine than below it. The space between the sacrum and the ilium is narrower below the posterior spine of the ilium and lies closer to the mid-line of the sacrum. Consequently, the needle is started closer to the mid-line and is directed a little less deeply than above. After each injection the patient pursues his usual activities.

FREQENCY OF TREATMENTS

The treatments are usually given twice a week, but three a week may be given if necessary to shorten the course. Usually the patient is cured

by five or seven treatments. In less severe cases two treatments may suffice.

The treatments are discontinued when the patient is assured by his own activities that he has recovered.

As the joint becomes stabilized, the pain disappears promptly, and the patient gradually resumes his former activities. No waiting period is necessary, but unnecessarily strenuous activity is avoided for several weeks.

The patient returns for re-evaluation two weeks after the last treatment and then at longer intervals. Failure of joint stabilization or residual pain indicates additional treatments.

For several years the author did not treat any patient by injection whose symptoms were of less than three months' duration. In recent years he has treated patients with severe symptoms of a few weeks' duration after the acute symptoms had disappeared, if he was convinced that the severity of the ligamentous tear would result in a permanent relaxation. This earlier treatment in severe uncomplicated cases relieves the suffering, permits earlier resumption of activities, and probably prevents a later relaxation of the ligament, since the sclerosing solution is injected during the stage of inflammation.

The relief of pain in acute sacroiliac strain by the injection of anesthestic oil has been described by Kirschbaum.

DRUG THERAPY

Medication during treatment consists of acetylsalicylic acid, 0.6 gram, with or without codeine, 30 to 60 milligrams, or demerol,® 50 milligrams. A few patients never need any analgesics. In the others the amount varies greatly. It is advisable to insist on comfort in order that the patient will not dread the treatment or aftereffects. In some instances an analgesic is administered one hour before treatment. With the use of long-lasting anesthesia the stronger analgesics are less often necessary.

ADDITIONAL THERAPY

An ice bag rather than heat is advised for pain between treatments, but this also is seldom necessary when long-lasting local anesthesia is used.

The elimination of obesity with its resulting change in posture and strain will frequently ameliorate the symptoms in a variety of low-back disorders, including sacroiliac relaxation. Weight loss will often obviate the necessity of operation in cases of lumbosacral and questionable disc involvement.

Some of the more recently developed local anesthetics have a more prolonged effect. Among these should be mentioned eucupine and quinocaine.®

ADDITIONAL CONSIDERATIONS

One should realize that the use of an anesthetic which lasts for a period of days or weeks instead of hours in the treatment of this disability may cause the patients to assume they are cured before they have received enough injections of the sclerosing solution to stabilize the joint. However, the increased comfort of the patient obtained with these anesthetic agents strongly recommends their use.

The sclerosing solution is not given at the time of diagnosis, because the needle has been withdrawn after the injection of the local anesthetic to permit activity of the patient and to observe the effect of the injection. The sclerosing solution is given on the second visit to the office, two or three days later. This assists in gaining the patient's confidence on the first visit.

Subluxations of the sacroiliac joint of variable degree sometimes accompany relaxation of the ligaments. Reduction will sometimes facilitate favorable results from injection (Case 16). A method used successfully by the author in several cases is to have the patient lie on his back on the treatment table after the posterior sacroiliac ligament has been infiltrated with a local anesthetic. The knee and hip on the affected side are flexed to right angles. An assistant presses down on the chest and on the opposite side of the pelvis. The operator grasps the raised ankle for control with one hand, and with his other forearm applies upward traction to the flexed knee. The traction is maintained while the thigh and leg are lowered to the table.

No reduction procedures should be used in postpartum cases unless these patients have not responded to the injection treatment at the end of a few weeks.

CASE REPORTS

In the following cases the patients were free from symptoms within two weeks or less after the last injection and were able to resume their former activities within a few weeks. Prolonged-action anesthesia was not used in any of the cases reported in this article. The author has found eucupine with procaine solution satisfactory as a local anesthetic. The sclerosing solution in use is sylnasol.®

Case 1, a nurse, aged 32. The symptoms, of 8 months' duration, had developed while she was lifting a heavy patient from floor to bed. Upon her admission to the hospital, two orthopedic surgeons diagnosed a disc injury and advised operation. An injection of novocaine® with saline into the caudal canal resulted in no benefit. The patient had eight sclerosing injections in one month, during which she was working. She has remained cured for seven years. When she was last seen, in April 1953, she was engaged in her occupation as a nurse.

Case 2, a farmer, aged 44. His symptoms, of two years' duration, had begun while he was carrying a hog downstairs. He was unable to do light work. After seven injections within one month he was able to run a tractor with a plow attached and to reach all levers. He was last

seen in June 1952, and he has been cured for eight years.

Case 3, an executive, aged 51. The symptoms, of twenty years' duration, had begun when he was carrying a piano. The pain was referred down the lateral aspect of the thigh and the leg when he was carrying objects such as a heavy traveling bag. He alternately wore three sacroiliac belts. He had five injections in a period of three weeks, after which he was able to play golf without a sacroiliac belt. He remained cured for eight years and died of a cerebral accident.

Case 4, a housewife, aged 42. Her symptoms, which had lasted 20 years, began during the second of three pregnancies. She had five injections during a period of three weeks. She has remained cured for ten years; since her cure she has worked in a factory and cared for her house. She was last seen in November, 1952.

Case 5, a housewife, aged 49. Her symptoms had lasted for 11 years. She had undergone hysterectomy and bilateral salpingectomy one year before examination, but these procedures had not affected her low-back pain. She had eight injections during a period of five weeks and has remained cured for five years. Her last examination was in May, 1950.

Case 6, an executive, aged 30. His symptoms, which had lasted for eight years, had begun while he was doing the high jump at college. Three years later they had been aggravated when he was loading quarters of beef. He had five injections within three weeks. He has remained cured for five years. He was last seen in December, 1952.

Case 7, a painter, aged 37, had a fall in which he fractured his skull and sprained his ankle. Three months later sacroiliac disability was diagnosed. He received eight injections in five weeks. He has remained cured for 12 years. His last examination was in October, 1952.

Case 8, a railroad engineer, aged 63, was thrown from his engine and fractured his sacrum. Six months later bilateral sacroiliac disability was diagnosed. During a seven-week period, he received six injections on the left side and eight injections on the right. He has remained cured for 11 years. He was last seen in August, 1952.

Case 9, a housewife, aged 34, mother of two children. Her pain, which had lasted for two years, had begun when she fell while playing baseball. She had had to be carried from the field and remained in bed for three days. A general surgeon taped her back; an orthopedic surgeon diagnosed rheumatism; another orthopedic surgeon found that one lower extremity was three inches shorter than the other; a neurosurgeon advised disc operation; a professor of orthopedics, after the patient had been hospitalized for three days, consulted with a neurologist and told the patient and her husband that "her legs were equal in length, she had a weak back, and there was nothing to be done for her." These doctors were all honorable, well trained, highly regarded specialists.

The patient was given five injections in three weeks. She has remained cured for three years. She was last seen in January, 1953.

Case 10, a housewife, aged 32. The patient sustained a low-back injury in an automobile accident. Six months later she was operated upon for removal of bilateral herniated fat pads in the sacral area. After one year she still felt no relief. The bilateral sacroiliac disability was cured, with five injections on the right side and six injections on the left during a seven-week period. She then remained cured until two years later, when she lifted a tub of water and symptoms recurred on the right side. She had four injections in two weeks and has remained cured for seven years. Her last examination was in October, 1951.

Case 11, a realtor, aged 62. His symptoms, of four months' duration, had begun when he lifted a meat block into an automobile. He had been treated by a competent osteopath without relief. He had been given large doses of analgesics at home before he was able to visit the author's office. He received six injections in three weeks and has remained cured for nine years. He was last seen in July, 1952.

Case 12, a physician, aged 52. His symptoms had lasted for eight years. He had been hospitalized under the care of an orthopedic surgeon, but was still unable to work. He received nine injections in five weeks. He has remained cured for five years and has lost no time from work. He was last seen in May, 1953.

Case 13, a schoolboy, aged 15, the youngest patient in this series. His symptoms, of 15 months' duration had resulted from an automobile accident. He received six injections in three weeks and was cured. In another automobile accident two years later he sustained a fractured skull but no sacroiliac disability. He has remained cured for six years. His last examination was in September, 1950.

Case 14, a housewife, aged 24. The symptoms, which were bilateral, developed six months after her honeymoon. She received two injections on each side, one day intervening between injections. She remained cured for two years. During her first confinement she experienced recurrence on one side; this was cured with one injection. She has had two confinements since. She now fells trees with a crosscut saw and carries wood. There has been no recurrence for six years; she was last seen in December, 1952.

Case 15, a housewife, aged 26, the mother of two children. In an automobile accident she sustained a fracture of the right femur. Four months later, when she resumed her activities, sacroiliac pain developed on the right. She had six injections in six weeks. She has remained cured for nine years; her last examination was in September, 1950.

Case 16, a female taxi driver, 40 years old. The taxi which she was driving was in a rear-end collision and she was lifted limp from it. She was found to have a sprained neck with concussion of the spinal cord and was hospitalized for four weeks. Sacroiliac pain on the right developed one week later. She was given eight injections in five weeks and resumed her former activities after three months. She remained cured for eight years.

In June, 1952, her symptoms recurred when she bent forward to lift something from the bottom of a barrel; she stated she felt a "snap" in her right hip and severe pain. She was given two injections without relief. After the third injection upward traction on the extremity with the knee and hip flexed and the patient in the supine position, reduced what appeared to be a very slight subluxation and assisted in the cure. She had been entirely free from pain for

seven months when she was last seen in January, 1953.

Case 17, a life insurance agent, aged 50. His symptoms, of 22 years' duration, had begun when he was in action with the United States Army in 1918. In 1928 at an internationally known clinic a diagnosis of generalized osteo-arthritis of the spine and sacroiliac disability on the right was made. In 1940 he had an acute exacerbation of the sacroiliac disability. Roentgenograms revealed osteo-arthritis of the lumbar spine and pelvis. After four injections in two weeks he was free of symptoms and was able to do spading in his garden. His last examination was in January, 1953. At that time he had been cured for twelve years. He has never suffered or been idle because of his arthritis, although the movements of his lumbar spine are limited.

RESULTS

In the past 14 years the author has treated 253 patients with relaxation of the posterior sacroiliac ligament. During that time he has surveyed and made a diagnosis in an equal number of patients referred for examination only. Most of the patients in this latter group had hitherto had some form of treatment, but in fully half of them the sacroiliac disability had not been recognized. In this series of approximately 500 cases only one or two were encountered for which the author would possibly consider fusion operation.

Of these 253 patients treated, 53 per cent were female. The longest period of disability before successful treatment was 30 years. The longest period of cure was 14 years. The oldest patient was aged 70 years and the youngest was 15.

A survey of the 197 cases of sacroiliac relaxation which were treated during the 12 year period between 1939 and 1950 inclusive has been compiled. An effort was made to contact each patient. Follow-up data has been obtained from 84 patients—37 by personal examination and 47 by answers to a detailed questionnaire. The average duration of disability before treatment was 4½ years. Of the 84 patients, 69, or 82 per cent, considered themselves entirely cured at the time of their last contact. Eighteen patients had been free of symptoms for 11 to 14 years, twenty-one patients have observed no symptoms for 7 to 10 years, and thirty individuals have been free of pain for 2 to 6 years.

The failures may be attributed to the following causes: (1) Diagnosis—where the diagnosis is not definite and cannot be clearly confirmed by the injection of a local anesthetic. (2) Failure of the patient to return until enough treatments have been given. (3) Treatment given in the presence of some other known or suspected disability which later becomes more aggravated although the sacroiliac relaxation may have been benefitted or cured. (4) All the patients in this series were diagnosed and treated with a 24-gauge needle 1½ inches long which failed to reach the required depth in heavier patients. A 2½ inch needle is now being used in these cases.

The percentage of failure could be reduced to a minimum if only those patients were treated in whom the diagnosis is definite and confirmed, and those cases were omitted which are complicated by some other low-back disability.

SUMMARY

1. Ligamento-sclerotherapy is valuable in the treatment of disabled joints.

2. During the course of treatment the patient usually continues his customary activities.

3. It is the author's observation that relaxation of the posterior sacroiliac ligament is one of the most frequent causes of low-back disability.

4. A careful history and physical examination are especially important to determine the seat of pain and point tenderness, and the area of referred pain.

5. Confirmation of the diagnosis is made by the injection of a local anesthetic into the ligament abolishing or relieving the pain.

6. Roentgenograms are usually of no value in determining relaxation of the posterior sacroiliac ligament but are valuable in determining congenital or acquired deformities or bone lesions.

7. Recurrences rarely occur. Complete confidence is gained.

8. In the past 14 years, 253 patients have been treated. Relief of symptoms ranging up to 14 years has been attained in 82 per cent of the cases. No unfavorable incident has occurred.

Acknowledgment: Illustrations for Fig. 1 and Fig. 2 used in this article, are reproduced from *D. J. Cunningham: Textbook of Anatomy, New York, William Wood & Co., 1909, pp. 290-291,* through the courtesy of Williams & Wilkins Co., Baltimore, Md.

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Infectious Eczematoid Dermatitis

Infectious eczematoid dermatitis is a nonspecific disorder, caused by a variety of factors, more than one of which may be present in any given case. Allergy, autosensitization, psychosomatic causes, and overtreatment and mismanagement of simple dermatitis are among the most important reasons for its development and persistence.—C. Barrett Kennedy, M. D., et al., New Orleans: *Southern M. J.*, 46:701, July, 1953.

The Use of Buthoids® (Butaphyllamine® Suppositories)* As Adjuncts in the Treatment of Cardiovascular Disease

DALE P. OSBORN, M. D.

THE use of xanthine derivatives in the treatment of angina pectoris was probably first described in 1895 by Askanazy who used theobromine sodium salicylate.[1] The original preparation of theophylline itself from tea leaves was described by Kossel in 1889.[2] Because of the high cost (12,000 marks per kilogram), there were very few pharmacologic or clinical studies with this material until it was synthesized in 1900 by Traube.[3] The use of theophylline as a diuretic was reported in 1902[4] and soon confirmed in human subjects[5-7] and in experimental animals.[8, 9]

XANTHINE CARDIOVASCULAR EFFECTS

Heathcote studied the effects of xanthine derivatives upon the rate of perfusion through coronary vessels in experimental animals.[10] Although a pronounced increase was noted with high concentrations of all three compounds tested, in dilutions of 1:20,000 to 1:40,000 caffeine produced no change, theobromine very little change, but theophylline produced an increase of 20 to 30 per cent.

In 1923 the favorable results from theophylline therapy in arteriosclerotic cardiac disease was ascribed by Guggenheimer to the dilatation of the coronary vessels rather than to the diuretic effect[11] and in 1935 it was shown that theophylline promotes the development of collateral circulation in experimentally induced cardiac infarction in the dog.[12]

Oral theophylline therapy has been reported as of benefit in 59 per cent of a series of patients suffering from angina pectoris, with 12 per cent of patients showing increases of 50 to 100 per cent in exercise tolerance.[13] Intravenous theophylline was reported as prolonging by 63 per cent the time of appearance of pain and reducing by 58 per cent the RS-T deviations in patients with the anginal syndrome.[14]

The first soluble salt of theophylline to be studied was the sodium acetate described by Alkan and Arnheim in 1904.[15] Diethylene diamine was added to theophylline ("aminophylline") with the object of enhancing the coronary dilating effect of theophylline; the effect of diethylene diamine, however, appears to be limited largely to increasing the solubility of the material.[16] The favorable effect of theophylline upon dyspnea was described by Singer in 1927.[17] It is associated with a decrease in venous and intrathecal pressure, and may be due in part to relaxation of bronchiolar spasm.[18]

Since sudden death was reported[19] following intravenous administration of aminophylline, recent work has been concerned largely with other methods of administration. The various xanthine preparations, including theophylline, are noted for producing gastrointestinal irritation, so that gastric discomfort, nausea, and vomiting are commonly associated with the oral route of administration.[20] In the past this has been true even following rectal administration.

NEW THEOPHYLLINE DERIVATIVE

Recently, the aminoisobutanol derivative of theophylline (butaphyllamine®) has been prepared. Acute and chronic toxicity studies in animals indicate that it is comparable to theophylline ethylenediamine.[21] In the heart lung preparation, when the heart is made to fail with chloral hydrate, butaphyllamine® increases the cardiac output, restores the dilated heart to its normal size, and decreases venous pressure.[22, 23] The equivocal clinical results following oral administration of butaphyllamine® in the treatment of angina pectoris may have been due to the limitation in dosage, since the maximal tolerated doses were six grains three times daily.[24] Oral doses of one to two grains of butaphyllamine® in combination with nethamine,® decapryn® and phenobarbital have been well tolerated and generally effective in the treatment of asthma.[25-29]

Butaphyllamine® has been used by the writer in several types of cases: coronary occlusion; dyspnea associated with congestive heart failure; coronary insufficiency with anginal symptoms; and bronchial asthma. Intravenous theophylline was abandoned when reports of sudden death appeared in the literature.[19] Adequate dosage by mouth has been impractical because of gastric

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*Butphyllamine,® Buthoids,® Decapryn,® and Nethamine® are trade marks of The Wm. S. Merrell Company, Cincinnati 15, Ohio.

Presented before the American Therapeutic Society at its meeting in Chicago, 1952.
Submitted May 4, 1953.

irritation, and intramuscular or subcutaneous injection has been sufficiently painful to limit somewhat its field of usefulness.

Rectal administration of theophylline ethylenediamine has been effective and initial administration has been generally well tolerated. Continued administration over a period of time has been necessary in these cases, and generally after seven to ten days most cases unfortunately develop signs and symptoms of local irritation, usually consisting of severe inflammation of the rectal mucosa and considerable local pain. The use of ethyl aminobenzoate as a local anesthetic has not been effective in permitting patients sensitive to theophylline ethylenediamine suppositories to continue treatment.

CLINICAL USE

For the past three years, butaphyllamine® suppositories which are now designated as "Buthoids"® have been used, and in all eighty-six (86) cases under study, there has been no evidence of local irritation. Each suppository contains 7-1/2 grains of theophylline aminoisobutanol in a special base, the principal ingredient of which is sorbide monostearate. This base absorbs substantial quantities of water after administration, causing the suppository to swell and conform to the shape of the lower rectum forming a self-emulsified ointment mass. The eighty-six cases were divided as follows:

Dyspnea as a result of congestive failure, 52 cases.

Acute coronary occlusion, 24 cases.

Coronary insufficiency with surgical symptoms, 6 cases.

Bronchial asthma, 4 cases.

In the case of dyspnea, one suppository may be administered as often as every eight hours. In paroxysmal nocturnal dyspnea, one at bedtime usually controls the distress. In general, patients with congestive failure tend to continue treatment more or less indefinitely. The longest period of any one patient under such therapy with buthoids® is three years.

In cases of coronary occlusion, immediate therapy consists of an intravenous injection of 1/50 grain of atropine sulfate, followed by an intramuscular injection of 7-1/2 grains theophylline ethylenediamine. Four hours later 1/150 grain atropine is given subcutaneously, and for the remainder of the first 24 hours, subcutaneous atropine and intramuscular theophylline ethylenediamine are alternated every four hours. Phenobarbital is given to allay anxiety. The intramuscular injection of theophylline ethylenediamine is, unfortunately, accompanied by considerable pain at the site of the injection. On the second day, buthoids® are substituted for the parenteral theophylline ethylenediamine and they are continued every eight hours for a total of three weeks.

ADVANTAGES OF BUTAPHYLLAMINE®

In a series of twenty-four (24) cases of coronary occlusion, there have been no instances of rectal irritation, even at the end of the three week period of buthoids.® We have been impressed with the incidents of death in coronary occlusion accompanying the use of large doses of morphine to control the pain. We have found by the foregoing regime that the pain is controlled in almost every case without the use of morphine, or at the very most, with very small doses of a morphine derivative. We use 1/128 grain dilaudid.® We find that this controls the pain satisfactorily.

This particular regime in the treatment of coronary occlusion was started following the work of LeRoy and Snider.[30] We found that all of our deaths were in those cases which had received large doses of morphine before we were able to start the treatment. We believe the sudden death is the result of the "reflex coronary vasoconstriction whose stimulus is the infarct, whose afferent pathway is the cardiosensory innervation, and whose efferent pathway is the vagus."[30] Death is due to fatal ventricular fibrillation. Large doses of atropine and the xanthine derivatives decrease the lethal reflex.

SUMMARY AND CONCLUSIONS

Butaphyllamine® is a new salt of theophylline which may be administered in a suppository (buthoids®), the principal ingredient of which is sorbide monostearate. It produces the usual therapeutic effects of theophylline in the treatment of nocturnal dyspnea and the post-coronary syndrome but buthoids® do not cause local irritation, as has been commonly observed with older suppositories of theophylline.

Acknowledgment. The author gratefully acknowledges the kind assistance of Raymond C. Pogge, M. D., Director of Medical Research, The Wm. S. Merrell Co., who provided the historical and chemical data for this paper.

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After-Cough Fainting—a Complication In Bronchial Asthma

Although not frequent, the occurrence of fainting following cough is a complication in bronchial asthma of which few physicians are aware. Failure to recognize this syndrome in asthmatic patients leads to confusion to the physician, needless consultation to the patient, and undue apprehension to both. The syndrome of syncope following cough has been reported under a variety of terms. Among these names are laryngeal vertigo, laryngeal ictus, laryngeal apoplexy, bronchial syncope, cough syndrome, tussive syncope, post-tussive syncope, tussigenic ictus and many others.

The first instance of this condition was described by Charcot in 1876. It is likely that its occurrence was known to earlier physicians including Sydenham and Heberden. We have encountered thirty-five examples of this condition and have reported these in detail elsewhere.—Vincent J. Derbes, M. D., and Andrew Kerr, Jr., M. D., New Orleans: *Southern M. J.*, 46:701, July, 1953.

KEEPING UP WITH MEDICINE

• CORTISONE appears to augment the dangers of perforation of corneal ulcer as it does peptic ulcer.

* * *

• DESPITE the fact that from ancient times there have been numberless investigations of the subject, little progress has been made in the education of the psychology of Love.

* * *

• EVER SINCE the first Medicine Man recited his incantations, the lives and doings of physicians have had a strange fascination for the man on the street. The social responsibility of us men of medicine is therefore doubled.

* * *

• THE MOST suitable standard for body weight is the average weight at age 25 for individuals of a given sex and height.

* * *

• THE CRITICAL LEVEL of sodium chloride concentration below which no intestinal activity occurs spontaneously, or in response to prostigmin,® lies between 5 and 9 per liter for human intestine.

* * *

• CORTISONE leads to a storage of glycogen by the liver. The glycogen is largely derived from the protein of muscle. Cortisone mobilizes body protein. In the meantime it spares fat which may be mobilized, stored in the liver, or distributed throughout the body in a characteristic manner. On the administration of cortisone there is a tendency to retain water, sodium and chlorides while eliminating potassium. Probably the most important effect of cortisone to keep in mind is its masking of symptoms—pain, malaise, and fever.

* * *

• EPIDIDYMAL CYSTS are of no importance unless disabling on account of size.

* * *

• A NUMBER of cases have been reported in which considerable trouble from local necrosis has followed puncture wounds with aniline pencils.

* * *

• BLOOD TRANSFUSION neuritis is "an annoying feeling of needles and pins" along the back of the thumb and index finger following a transfusion into the vein at the wrist.

* * *

• THERE IS little doubt that cross-sensitizations are of greater importance than has heretofore been realized. The clinician should remember that his "sulpha" sensitized patient may also be sensitive then to hair dyes, sun-screening skin lotions, to many local anesthetics, dyes in nylon, other clothing, as well as the "safe" food colorings, to picric acid, aniline, and possibly saccharine.—J. F.

Progress in the Study of Hodgkin's Disease*

ANTONIO ROTTINO, M.D.

THE increase of interest and research in Hodgkin's disease during the past ten years owes much to the heroic efforts of Herman Hoster. This afternoon I shall review briefly some of his work, that of his associates, friends and others influenced by him.

ETIOLOGY OF HODGKIN'S DISEASE

Hoster believed firmly that the etiology of this illness which so tragically cut short his career was a virus. His first and main effort was therefore directed towards finding the organism and seeking means to combat it. With these objectives in mind he employed, for the first time in the search for an etiologic agent for Hodgkin's disease, embryonated eggs, a biologic tool used with great success in isolation of the influenza and other viruses.

The first fruit of his labor was the observation that the mortality amongst batches of eggs inoculated with Hodgkin's material was higher compared with batches into which non-Hodgkin's material was introduced. In subsequent serial passages, though these differences persisted, their magnitude was never sufficiently great to be considered by him significant.[1]

In 1947 Bostick[2] published results of experiments similar to those of Hoster. He concluded that "Serial passage in a total of 2,700 chicken eggs of extracts from 20 cases of Hodgkin's disease revealed a small but statistically significant greater mean mortality of the chick embryos from that of control series injected with extracts from other types of tumor and tissues."

In 1949, Karnofsky[3] reported upon work based likewise on eggs, but differing somewhat in technique. He implanted on the chorio-allantoic membrane of the chick a piece of tissue from Hodgkin's diseased lymph nodes. There was induced an unusual reaction in the chick embryo. In 3 to 5 days the latter developed generalized edema of severe degree. This reaction was invoked by nodes from two-thirds of all Hodgkin's patients—and by no tissue from patients with other diseases. Attempts to transmit this phenomenon through serial passage yielded negative results. In the opinion of Karnofsky, the edema incitant is a non-transmittable toxin.[4]

Dr. Walters,[5] in my laboratory, prepared an extract from Hodgkin's diseased nodes highly toxic to mice. Similar tissues affected by other diseases, extracted in like manner, proved nontoxic. It would appear, therefore, from all these works, that Hodgkin's tissue contains a toxic factor peculiar to it, but which as yet has not been isolated.

In 1944, Grand[6] published observation of cytoplasmic inclusion bodies in lymph nodes of Hodgkin's disease grown in tissue culture, and concluded that the inclusion bodies signified virus activity specific for this disease. Since his observations were new, fresh, and were obtained by a technique not hitherto used in the study of Hodgkin's disease, considerable interest was aroused; and efforts were made to duplicate the work since his conclusion, if correct, would have far-reaching significance.

After two years of study[7, 8] upon a large control material it was quite evident, to me at least, that Grand's observations were essentially correct as far as they went, but the interpretations and conclusions were not. In the first place, the multinucleated giant cells which were interpreted by him as representing Sternberg-Reed cells were in reality foreign body giant cells, and further, were non-specific. Secondly, specific cytoplasmic inclusion, if present, could not be differentiated from the myriads of other granules which quite obviously resulted from breakdown of nuclear material.

Soon after, Hoster, Porter and Jacques[9] acquiesced with this point of view. These workers next subjected Hodgkin's disease nodes grown in tissue culture to the electron microscope hoping, thereby, to demonstrate virus particles. Neither Porter and Jacques[9] nor the Hosters[10] had success. Mrs. Miriam Hoster[11] extended the search further by experimentation with differential centrifugation attempting to isolate thereby some one particulate peculiar to Hodgkin's diseased cells. The results are too complex to permit simple conclusions.

TREATMENT

Perhaps the greatest progress in the Hodgkin's problem has been in the field of therapy. To one satisfied with nothing short of a cure the progress will be very disappointing. To the rest of us

The Author

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who are grateful for anything that will add to the comfort of the patient no matter how short-lived it may be, the newly discovered chemotherapeutic agents represent a remarkable advance. Amongst these agents the mustards and mustard-acting drugs (TEM) head the list.[12]

In selected cases both drugs have dramatic specific action. Cortisone and ACTH have limited use since only very few Hodgkin's patients are helped. The value of adenylic acid[13] is also limited to a highly selected group, difficult to differentiate from the larger group who will not be benefited. The interest in these latter drugs is academic, since their action when understood may lead to the understanding of pathologic physiologic mechanisms.

One drug I would like to recommend to you on the basis of work extending over a period of the past 15 months and which as yet is unpublished, is butazolidin.® With this drug one is able to control pain, fever, and to some extent, pruritus. It also produces in selected cases a feeling of well-being, improves appetite and dissipates feeling of fatigue—symptoms so common in Hodgkin's disease. We have also seen nodes regress during its administration. I cannot go further into the matter of therapy—time will not permit me to do so.

MICROPATHOLOGY OF HODGKIN'S DISEASE

I could spend the time which remains discussing immunologic studies in Hodgkin's disease of which there are many, and in particular, the careful, laborious work of Mrs. Hoster.[14] However, since the results have proven negative, it would be pointless at a meeting such as this to go into the matter further.

It would appear that most paths pursued thus far by research effort have led to a hard impenetrable wall—indicating either our theories about Hodgkin's disease are wrong and that it occupies a position unique in the category of disease, or we have not yet used the proper tools to pry into the secret of its nature. In any event, when a dilemma such as this is reached the wise thing to do is to go back to the patient, re-examine clinical and autopsy material and search for missing factors. I have done this repeatedly with the necropsy material and each time I have been impressed by one constant feature relating to the pathologic process. It is this which I would like now to demonstrate.

In the first, early or preliminary phase of the disease the node enlargement is observed to be due to hyperplasia of the small lymphocytes. Scattered through the node, inconspicuous and sometimes difficult to find, are enlarged reticulum cells, with swollen nuclei containing a prominent nucleolus. Eosinophiles and Sternberg-Reed cells may or may not be present.

As time goes on the numbers of lymphocytes begin to diminish and the reticulum cell forms increase until they dominate the picture.

Later, even these begin to undergo atrophy so that eventually the lymph node persists as an enlarged fibrous structure, the ultimate result being complete destruction of the lymphoid system, exhaustion of the lymphoid elements, and inability to regenerate the lymphocyte beyond a minimum degree.

In a small group of cases, the direction of change is quite different from that which I have just described. Instead of the reticular elements undergoing atrophy, they proliferate and form true infiltrating neoplastic growths.

There is one further point I should like to develop in the dynamics of the Hodgkin's process —namely the histology of a new node which appears for the first time late in the disease. Early in our studies when our experience was less than it is now—a node was obtained from a patient at such a period, only a few days after it had made its appearance. Instead of the histology of early Hodgkin's which I expected to see, one observed simply many fibroblasts, fibrous tissue, and normal appearing reticulum cells with a few abnormal forms and Sternberg-Reed cells. In other words, though it had enlarged only recently, the node reflected the advanced status of the disease. It did not go through a phase of lymphoid hyperplasia, reticulum dedifferentiation and degeneration and then fibrosis. This observation has been duplicated several times in patients upon whom biopsies have been done periodically over the years and indicates to me profound physiologic alteration of the lymphoid system. This alteration may be the reason for the irreversibility and inevitable fatal outcome of Hodgkin's lymphogranuloma.

THE SIGNIFICANCE OF THE MICROPATHOLOGY

When the pathologic process is viewed thus as a dynamic process and its consequences pondered over, certain questions arise: (1) How long does it take for all this to develop and run its course? (2) What factors control it? (3) What is its significance?

In the first place the tempo of the various anatomical steps varies from individual to individual. One patient I followed had a paragranuloma type of node at the initial biopsy. A year later, at autopsy, every node was fibrosed, and the gastrointestinal tract and spleen devoid of lymphoid cells. Parker and Jackson[15] cite one patient with a biopsied node showing paragranuloma in whom, 35 years later, a second biopsy revealed the same. Why such extreme differences in behavior? We do not have the answer. The best we can do is postulate that in some way it must be linked to the immunologic processes of the individual, and secondly, upon the potency of the specific toxic causative factor.

The clinical significance of this pathologic

process which ultimately destroys the lymphoid system is evident to those having wide experience with Hodgkin's patients. In the first place, the rapidity with which the end stage is reached is reflected in the acuteness or chronicity of the clinical course. Further, there is a correlation between response to therapy and the anatomical composition of the node. It is well known that response to therapy is best when nodes are predominantly lymphocytic and poor when the fibrotic phase is reached.

It would appear, therefore, that the integrity of the lymphoid system is important to the body economy. Just as the ultimate course of rheumatic fever depends upon the degree of anatomic damage to the heart and the extent to which cardiac physiology is altered, so the ultimate course of Hodgkin's disease may depend upon the extent the lymphoid system is destroyed and the tempo with which this is done.

It would appear to me, therefore, that a fruitful field for research would be one which lies still on the frontiers of the unknown—namely, the physiology of the lymphoid system; a difficult field, difficult to grapple and one about which knowledge is in a confused state.

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Polyarteritis nodosa is a disease of many names possessing more than 15 synonyms. The most frequently used are: periarteritis nodosa, polyarteritis, panarteritis, necrotizing arteritis, primary arteritis, and essential polyarteritis.—D. E. Ray, M. D., J. Kansas M. S., 54:396, August, 1953.

Proper Diet for Gallbladder Disease Patients with Food Allergies

In patients with food allergies, offending foods must be removed from the diet. Milk is the most common and also the most difficult food to eliminate, but gelatin in plain water or in one of the soybean milk substitutes may be substituted. If this diet is instituted immediately after subsidence of an attack of colic, it will usually prevent the recurrence of a succession of attacks, which is such a distressing occurrence. When it is begun in a patient who has had constant distress for some time, the diet may provoke an attack of colic, although usually not one that cannot be controlled easily, as I have suggested, or it may simply cause an exacerbation of symptoms. I usually tell the patient that this exacerbation is to be expected because a "sick gallbladder is being put to work" and that it will subside after a period of a week or ten days. If it occurs at all, the exacerbation usually subsides in a few days and is followed by a sense of well-being, the patient often saying that she has not felt so well in years. Meats are gradually added to the diet after a month or six weeks.

Medication is not required, but in very nervous individuals a little phenobarbital may be used sparingly for a couple of days. Usually in a month, but sometimes only after two or three months, a nonfunctioning or poorly functioning gallbladder can be demonstrated to have had its function restored. I usually get repeated cholecystographic studies at monthly intervals. If these show no improvement, if symptoms persist or are aggravated, and if there are no contraindications present, surgical treatment must be considered.

In addition to the use of dietary measures, every patient should receive careful treatment for any other conditions found during the complete study, and prophylactic treatment should not be neglected. The diet suggested would be entirely suitable for patients with peptic ulcer or any other gastrointestinal condition. It would answer the requirement in cardiovascular and renal disease and could be easily adapted to the patient with diabetes. Forced feedings would help to control the vomiting of pregnancy. Its caloric value can be modified to provide adequate nutrition for a tuberculous patient or reduce weight in the obese. Increasing its carbohydrate and vitamin content will help in cases with marked liver damage. If instituted immediately after operation, it will promote biliary drainage, prevent most of the troublesome postoperative complications, avoid constipation and distention, and provide adequate nutrition to help in convalescence.—Albert F. R. Andresen, M. D., Brooklyn: *New York State J. M.*, 53:1770, August 1, 1953.

Present Day Lag in the Treatment of Tuberculosis

ROBERT H. BROWNING, M. D.

IN observing patients admitted to the Ohio Tuberculosis Hospital from more than 65 of Ohio's 88 counties, one is conscious of a considerable lag in applying present knowledge of tuberculosis treatment. In many instances, there has been misuse of anti-TB drugs or a failure to combine them properly with rest, collapse therapy or resectional surgery.

While drugs have radically changed many aspects of TB treatment, the principle still holds that drug therapy alone is not a safe treatment for tuberculosis. Only when combined with a sanatorium rest regimen and the judicious use of collapse and resectional procedures, are optimum results attained. We have seen a number of patients whose recovery has been jeopardized by attempts at short-cut drug therapy used at home.

THE CHANGING USE OF ANTI-TB DRUGS

The duration of drug therapy in tuberculosis is increasing. Periods of continuous use from one to two years or even longer are not uncommon. Short courses such as 6 weeks, 90 days, or 120 days are things of the past, controlled studies having demonstrated that intermittent therapy is less effective than the continuous administration of drugs.

In the early use of streptomycin, there were two major problems: the toxicity of the drug and the emergence of resistant strains of tubercle bacilli. Fortunately, it has been demonstrated that the 2 gram daily dosage originally used is not necessary. Equally good results are obtained with 1 gram given twice weekly. With this reduction of dosage, eighth cranial nerve damage, so common formerly, is now a rather minor problem.

Bacterial resistance is a constant threat, to be minimized by proper combinations and dosages of drugs. Neither streptomycin nor isoniazid should be used alone. Whether their routine combined use is to be recommended at this time is doubtful. The place of isoniazid in tuberculosis treatment is under vigorous study in many centers. That it is a potent and valuable drug can no longer be questioned. Just how it can be best utilized in the total picture of TB therapy remains to be seen. No one would question its use when resistance to streptomycin has developed, or when the results of other therapy are unsatisfactory, or in tuberculous meningitis or hematogenous tuberculosis.

The conventional combination of streptomycin and sodium PAS as outlined below has much to recommend it for routine use. Especially as regards the development of resistance, this regimen has seemed to be as effective as any and much better than some. When streptomycin is not well tolerated, a combination of isoniazid with sodium PAS can be substituted.

All too often we have seen the value of antituberculosis drugs frittered away because of failure to combine them properly. As a result, the patient may have to enter into critical surgical procedures without the protective bacterial suppression which can usually be provided by anti-microbial agents.

The ordinary case of active tuberculosis responds very well to streptomycin sulphate, 1 gram twice weekly injected intramuscularly and 12 grams of sodium PAS daily given in divided doses by mouth after meals. In the light of present knowledge, the addition of isoniazid to this regimen is gratuitous unless progress is unsatisfactory or resistance to streptomycin develops. Only in tuberculous meningitis has isoniazid seemed to have therapeutic qualities superior to those of streptomycin.

Rather than to "throw the book" at each new case of tuberculosis, it is wise to hold one potent drug in reserve, to be used if and when needed.

Submitted July 7, 1953.

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Increasing Frequency Expected In Sensitization to Drugs

The marvel is not that penicillin and other drugs can lead to tragedies, but rather that up to now such tragedies are relatively rare. They are almost certainly to be expected with increasing frequency, since the extremely widespread spectrum of usefulness of penicillin, which perhaps very often is not even really needed, can be expected to lead to increased use and to the sensitization of more and more people through its administration by physicians, or through self-medication. Death is much the same regardless of who is responsible for the unjustified uses and consequent liabilities.—A. L. Tatum, M. D., Madison: *Wisconsin M. J.*, 52:417, July, 1953.

What To Do About Strabismus

FRANK D. COSTENBADER, M.D.

WHEN contemplating the management of strabismus, the role of three interested groups of parties must be considered, in addition to the role played by the patient. The parents must, of necessity, understand what the ophthalmologist has in mind, and be able to cooperate fully with the treatment as it is presented. The referring physician, be he general practitioner, pediatrician, or some other specialist, must be able to recognize strabismus, be aware of the importance of early treatment, and refer the patient promptly to the ophthalmologist. The ophthalmologist, in turn, must confirm the diagnosis and have in mind a reasonable program of treatment.

The treatment of strabismus should be begun as early in life as it is possible to make a diagnosis, and should be carried through in a continuous and well integrated program until a cure or the best possible results have been obtained.

I. ROLE OF THE PARENTS

For purposes of simplicity, the role of the parents in the management of strabismus will be considered first. It is my practice, as soon as I have completed my initial examination, to discuss with the parents the findings presented, and their significance, and to outline tentatively what should be done. It is always well to emphasize that as time goes on, the program may have to be altered as additional findings come to light, or as certain findings change.

The discussion of strabismus with the parents should outline to them the clinical picture of strabismus as a whole, and then more specifically how this applies to their particular child. The story, as presented to the parents, is as follows:

"Strabismus, or crossed eyes, refers to any eyes that happen to be out of line. This is true whether they are constantly or only intermittently out of line, and whether of great or small degree. Strabismus is divided into two large classes, the convergent and the divergent.

CONVERGENT STRABISMUS

"The convergent strabismus is further divided into two sub-groups of major importance. The first is the 'effort' (accommodative) convergent strabismus. This is the type in which the eye muscles, nerves, and anatomy are essentially normal, and are perfectly capable of allowing the eyes to be straight when conditions are favorable. However, for one reason or another, these eyes have to strain more than is average in order to see well, and whenever this extra effort is called forth, the eyes cross. When effort is not being put out, the eyes tend to relax to straight or nearly so. This crossing is especially noticeable when the child is tired, ill, or looking hard at some visual detail.

"When the child with an effort squint is examined under drops, it is usually found that he has from a moderately strong to an excessively strong farsighted (hyperopic) type of error. This means that, under ordinary circumstances, he is having to strain unusually hard in order to see well, even at a distance, and especially hard when he attempts to see well up close. When the proper glasses are put on him, he then sees without effort, and so keeps his eyes straight. Occasionally, it is found that an additional strength of glass must be given him for near in order to allow the eyes to be straight for both distance and near. This is done in the form of bifocals.

"The treatment, then, for the pure effort type of squint is glasses during the early formative years, to allow the eyes to be straight and see together as much as possible. Later, when the age of readiness has been reached, exercises are given to teach the eyes to want to see together more securely. As the habit of seeing together becomes increasingly strong, the strength of the glasses may be progressively reduced, and at times the glasses may be completely discarded.

"The other sub-group of convergent strabismus is the 'mechanical' (non-accommodative) squint. In this type, the muscles, nerves, or other anatomy will not allow the eyes to be straight, even under the most favorable circumstances. This may be due to the fact that the anatomy was put together wrong when the baby was being formed, or that some changes have taken place subsequently. In any event, in the mechanical squint, the eyes have not the ability to become straight spontaneously. The treatment for the mechanical type of squint is surgery. It is not possible

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to change the anatomy of the eyes except by surgery.

"While many cases of convergent strabismus are purely effort or purely mechanical, a large group has some element of each. Thus, the eyes cannot become straight even when relaxed as much as possible (the mechanical element), and on the other hand, when effort is put out, the cross becomes appreciably greater (the effort element). In these combined types of strabismus, the treatment must fall into both fields—surgery for the mechanical, and glasses and later exercises for the effort.

DIVERGENT STRABISMUS

"The other large group of strabismus is the divergent. A fact not generally known is that most eyes do not have a straight 'position of rest' or 'natural position.' If the average individual is placed under an anesthetic so that the normal controls are no longer operative, the eyes will usually be somewhat divergent, occasionally slightly convergent, or at times will be elevated. This is the natural condition for most eyes. If, when the baby is being formed, the natural position is only slightly divergent or convergent, only moderately strong controls are needed to pull those eyes straight and to keep them well aligned throughout life, whenever the patient is conscious. These people are the ones who have completely straight eyes, or a latent tendency to diverge (exophoria).

"On the other hand, if the natural position is widely divergent, extremely strong controls would be necessary to pull these eyes straight and keep them there, and usually such controls are not available. These eyes stay widely divergent at all times, and surgery is necessary in order to set them straight. On the other hand, yet, if the divergent position is more moderate, the patient is able to straighten the eyes when feeling well, and when visually attentive, because at those times the controls are adequate. However, when tired, ill, emotionally upset, or visually inattentive, the controls are not adequate and the eyes relax to the divergent 'position of rest.' This intermittent exotropia must be taken care of by surgery and exercises usually."

HABIT OF "SEEING TOGETHER"

Treatment and its aims are better understood if some discussion of the alignment of the eyes, and the "seeing together" is enlarged upon to the parents.

"A thing not generally understood is that eyes stay straight in adult life because the 'habit of seeing together' has become well established in childhood, and this habit makes the eyes wish to stay straight later on. The strength of the eye muscles is of secondary importance in keeping the eyes straight under these conditions. The average adult, if forced to look cross-eyed, is much disturbed and confused, and will promptly place his eyes straight again in order to overcome his annoyance. His 'habit of seeing together' makes his eyes wish to stay straight at all times.

"On the other hand, if, during early childhood the eyes are seldom, if ever, straight, the habit of seeing together either may not develop or is very weak when it does develop, and the urge to stay straight is quite weak. Even if these eyes are straightened later in life, they are quite unstable eyes because the habit of seeing together is so weak. These eyes are just as happy when out of line as when in line (in contrast to the eyes which have developed a strong habit of seeing together).

"The foregoing facts make it very evident that the two most important things in the treatment of strabismus are, first, to obtain and maintain the best possible vision in each eye from as early in life as possible, and second, to align the eyes and keep them well aligned by whatever means, again, from as early in life as possible. Thus Nature has been given every opportunity of teaching the eyes to see together. This habit of seeing together may be reinforced at the age of readiness by giving the proper eye exercises (orthoptics), with the hope that eventually the habit of seeing together will be so secure that the eyes will wish to stay straight, and will resent becoming misaligned.

POSSIBLE RESULTS OF STRABISMUS

"If, perchance, eyes do go out of line and stay that way from early in life, several things may happen:

"(1) The individual, for a shorter or longer period, may see double or become visually confused because both eyes are trying to work at the same time but are not focussed on the same object. This double vision (diplopia) is quite confusing and Nature soon disposes of it by allowing the individual to ignore the vision in the eye which is out of line (suppression).

"(2) This suppression often takes place while the potential vision in the eye is still excellent. The mind has simply turned off the vision in order to avoid annoyance.

"(3) However, as time goes on and suppression constantly continues, the vision in the eye will deteriorate from lack of use (amblyopia ex anopsia), and if this condition comes on early enough in life and continues long enough, the vision may fail so far that it can be restored only with great difficulty, or not at all. Since lack of use is the cause of this poor vision, the only treatment is forced use, and the only way to force the use of an eye is to cover the 'good' or 'straight' eye constantly.

"One other thing may happen when eyes are constantly out of line. Just as when eyes are well aligned the habit of seeing together becomes well established, so when eyes are constantly out

of line, they make some effort to see together but in the abnormal position. This abnormal association of two visions (abnormal retinal correspondence) does help to relieve the individual of some annoyance, but also acts as a bar to the restoring of normal association of the two eyes.

TREATMENT

"In the treating of crossed eyes, these abnormal habits and patterns must be broken down in order to allow the normal habits to be set up again. The over-all treatment of crossed eyes may consist of any or all of the following:

1. Covering of an eye in order to improve the vision of the other eye and to break up abnormal habits.
2. Glasses in order to allow the eyes to see better and to align themselves better.
3. Surgery to help align the eyes better, and
4. Exercises (orthoptics) in order to encourage the eyes to see together normally and securely.

The treating of crossed eyes must be begun early and carried through as a reasonably continuous program in order to be fully effective."

II. ROLE OF REFERRING PHYSICIAN

Having reviewed the explanation which has been offered to parents on the subject of crossed eyes, it is easier to understand the role which the referring medical man must assume. It is his responsibility to recognize strabismus or to confirm the parent's suspicion, just as early in life as possible, and to refer this patient for treatment when he has assured himself that strabismus is present. The referring practitioner may well wish to do two things:

(1) He may wish to get an estimate of the ocular alignment. This can rarely be done by simply observing the eyes. A baby's or small child's features may frequently give the appearance of convergent or of divergent strabismus when actually the visual axes are perfectly straight and the eyes well aligned. On the other hand, at times the eyes will not appear to be particularly out of line, and yet on more accurate checking a true strabismus will be found to be present. These illusions are influenced by the size and shape of the palpebral fissures, the flatness and breadth of the bridge of the nose, the width of the face, the interpupillary distance, and any facial asymmetry.

The simplest method of estimating the ocular alignment is to have the child or baby fixate an object of interest at a distance of some 10 to 13 inches. This object may be a small toy, pocket flash-light, or some noise making object. After the patient's interest has been engaged, the hand is then slipped before one eye. If the other eye does not have to move in order to fixate the toy or light, the visual axis was well aligned in this eye in the first place. Then the examiner's hand is slipped before the other eye, and if the second eye does not have to move in order to view the object of interest, it also was well aligned.

Thus, if the two eyes can be covered alternately in the process of playing with the child, and no ocular movement takes place, the eyes are well aligned and no strabismus is present, even though the appearance may be there. However, if on covering one eye, the other eye has to shift materially in order to view the object of interest, or if it rolls about aimlessly, either strabismus is present or vision is poor in the uncovered eye, or both. Either of these two things is adequate cause for referring the patient for further treatment.

(2) The other thing which may be ascertained by the referring physician is a rough estimate of the visual acuity in each eye of the child. If the child is a baby, the above-mentioned method of fixating a light, and covering first one eye and then the other is the best method of examination. As stated, if when one eye is covered, the child seems unable to fixate the light with the other eye, or makes forcible efforts to remove his eye from behind the cover, the vision is probably poor in the eye which had not been covered.

If the child is between the ages of four and seven, the illiterate 'E' chart may be used effectively to determine accurately the vision in each eye. If the child is above the age of seven, the ordinary alphabet Snellen chart may be used to so determine his visual acuity. It should be emphasized that the vision in each eye should be estimated, since a child may show no visual handicap if his vision is good in one eye, even though absolutely blind in the other.

Again, if the referring physician (be he general practitioner, pediatrician or other specialist) suspects that strabismus is present or that poor vision is present in one eye or both after reasonable screening, the patient should be referred to the ophthalmologist early in life.

III. THE OPHTHALMOLOGIST'S ROLE

When the patient is received in the ophthalmologist's office, the problem is one of confirming the diagnosis, outlining treatment, and discussing therapy with the parents.

EXAMINATION

The necessary minimum of examination on the part of the ophthalmologist should include:

(1) **The deviation should be confirmed.** This may be done at times by simply repeating the cover test as done by the referring physician, or in somewhat older patients, by measuring the deviation with prisms, by estimating the corneal reflex, or by measuring on certain instruments adapted for this purpose. A reasonably accurate

estimate of the convergent or divergent position under various conditions is important.

(2) **The visual acuity** should be further estimated, either by noting the patient's ability to fixate with each eye, by examining on the illiterate 'E' or on the alphabet Snellen chart.

(3) **The refractive error** should be accurately determined by checking the patient under cycloplegic (usually atropine used at home for three days prior to the examination). This examination allows the ophthalmologist to determine whether glasses will probably be effective, and to what extent. At the same time, any fundus pathology as a cause for poor vision can be determined.

(4) **The binocular vision** should be evaluated by means of several different tests. What effort are these eyes making to see together, and how satisfactory is the result? Is the patient seeing double? Can he be made to see double under proper testing methods? Does he completely suppress one eye? Does he have poor vision in one eye, in addition? Does he have an abnormal association of the two visions (abnormal retinal correspondence)?

All of these things are of vital interest before deciding what the treatment shall be, what the prognosis is. It should be recalled from the discussion of the situation with the parents, that the treatment of convergent strabismus may be occlusion of one eye for poor vision in the other, glasses to help align the eyes better and to help them see better, surgery to help alignment, and/or exercises to encourage the habit of seeing together. In divergent strabismus, again, the treatment may be surgery or exercises or a combination of the two. Glasses are rarely helpful, and frequently occlusion is not necessary or helpful.

SUMMARY

By way of summary, I might remind you that three interested groups of persons play a part in helping the cross-eyed child to overcome his handicap. The parents must appreciate the situation, understand what the ophthalmologist is trying to do, and cooperate fully. The referring physician should refer the patient just as early as strabismus can reasonably be confirmed or poor vision suspected. The ophthalmologist must treat the patient from as early in life as possible, and in as continuous a fashion as possible, in order to obtain the best possible results. A pair of eyes, each seeing well, well aligned, and seeing together securely, is a goal well worth fighting for.

Polyarteritis

It is interesting to note that polyarteritis is rarely associated with common forms of allergy in children.—Donald E. Ray, M. D., Kansas City; *J. Kansas M. S.*, 54:396, August, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Fibula—This Latin word designates a buckle, brooch or clasp and is derived from the Latin word "figo" meaning I fasten. This bone is so named because in some animals it is pointed at one end and thus resembles a pin or skewer and thus the relationship of the fibula to the tibia is that of a needle to a brooch. The Roman surgeons also used small pins or clasps called "fibulae" to unite the lips of wounds and this procedure was called infibulation.

Fulminating—This term which is used in medicine to describe a disease which is sudden, severe and rapid in its course is derived from the Latin word "fulmen" meaning a thunderbolt.

Gas—A word which was introduced by Joannes Baptiste von Helmont (1577-1644), a Belgian physician and chemist. In the course of his investigations of carbon dioxide he invented this word to signify the most volatile part of anything. He was most likely influenced by the German words "gascht" meaning a gust of wind and "geist" meaning a ghost or spirit.

Gag—This word is imitative of the "ga-ga-gaggen" sounds uttered when something is placed into the mouth as an obstruction. The middle English word "gaggen" means to suffocate and the Swiss word "gaggen" means to stutter. The use of the word "gag" as a means of preventing speech is an old one and so is the use of a "gag" in medicine to keep the jaws apart or open.

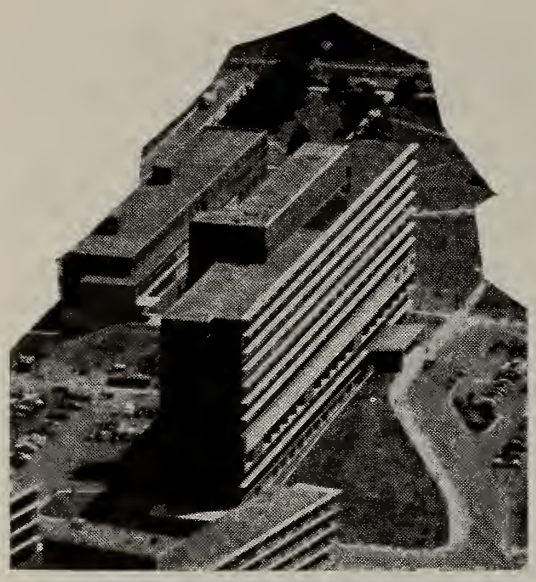
Gangrene—An ancient term used by Hippocrates, Galen and other Greco-Roman physicians for an eating sore which ended in mortification. The term is derived from the Greek word "gaggraina" an eating ulcer, and this in turn comes from the Greek "graino" meaning, I eat or gnaw. The word came into English via French in about 1500.

Gastrocnemius—The name of this large muscle in the calf of the leg literally means the "belly of the leg." It is derived from the Greek words "gaster" or belly and "kneme" or leg. This term was used by both Hippocrates and Galen and was later revived by the Belgian anatomist Spigelius in about 1600.

Gentian—This medicinal herb was known to the ancients and Pliny in the first century A. D. related that it was named after the Illyrian King Gentius who supposedly was the first to discover its medicinal properties in the second century B. C.

Gizzard—This word came into English from the provincial French words "grezie" or gizzard and "gres" or gravel. This term was applied to the strong muscular stomachs of birds because they always contain some gravel.

—Harry Wain, M. D., Mansfield, Ohio.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Edward Goodsitt, M. D., President

Presented by Robert M. Zollinger, M. D., and Emmerich von Haam, M. D. Edited by E. von Haam

PRESENTATION OF CASE

THE patient was a 76 year old man who came into the hospital with abdominal distention, nausea and vomiting. His condition was such that he was unable to give his own history; this was obtained from his daughter. Apparently he had been in good health until three months before entry, when he had an attack of "flu" from which he recovered somewhat slowly. About ten days before hospital admission the patient noted abdominal pain which was dull and persistent. Two days before admission nausea and vomiting became pronounced, the pain continued, and he noted marked constipation.

Physical Examination: Temperature 101.4°, pulse 120, respirations 32, blood pressure 90/68. The patient was a well developed, poorly nourished white male who showed dehydration and marked dyspnea and orthopnea. He was sweating profusely and his extremities were cold and clammy. The lungs were relatively clear to auscultation and percussion. The heart sounds were distant. The abdomen was tensely rigid in both lower quadrants, and tender to deep palpation. The fingernail beds and mucous membranes were cyanotic.

Laboratory and X-Ray Data: The admission blood count showed 7.55 million erythrocytes, 18.6 Gm. of hemoglobin, and 5,650 leukocytes with a differential count of 64 per cent neutrophils (55 non-segmented), 27 per cent lymphocytes, 1 per cent monocytes, and 8 per cent eosinophils. On the following day the leukocytes had risen to 20,600 with 85 per cent neutrophils of which 68 were non-segmented.

The admission urinalysis showed 15 mg. of sugar, was positive for acetone, showed a trace of diacetic acid, and contained 8 to 10 white blood cells and 4 to 6 red blood cells per high power field, with many bacteria and coarse granular casts. The Westergren sedimentation rate was 76 mm. in one hour. Blood sugar was 87 mg., blood urea nitrogen 15.5 mg., and CO_2 combining power 46 vol. per 100 cc. Blood amylase was 250 units; in the peritoneal fluid it was 2070 units.

Electrocardiogram showed changes in the ST segments usually seen in coronary disease but also occurring in upper abdominal disease. Flat plate of the abdomen was essentially negative.

Hospital Course: The patient received parenteral fluids and glucose (about 2000 cc. per day), digitalis, penicillin (50,000 units three times a day), and morphine sulfate. He grew steadily weaker, vomiting of fecal smelling material continued, and bowel sounds were almost inaudible. Moist rales were heard in both sides of the chest. The left arm showed evidence of thrombophlebitis. The pulse ranged between 110 and 130 per minute. Terminally the temperature rose to 104.4°. He expired on the third hospital day.

CLINICAL DISCUSSION

DR. R. M. ZOLLINGER: The diagnosis in this case was doubly difficult since no details could be obtained from the patient. He had all the signs of generalized peritonitis and in addition he gave evidence of being in shock: cold, clammy, perspiring extremities, with cyanotic nail beds. From the history given, it is only possible to discuss the steps which should be taken in making a diagnosis, and to consider various conditions which might have been present.

In the first place, the fact must be considered that older people do not respond as quickly or as severely to infections as those in the middle or younger age groups. There are at least three notable differences in the reactions of the younger group: a definiteness of onset; a marked and

sudden rise in temperature in the young, which is not manifested in the elderly; and a greater toleration of pain exhibited by the elderly. It is a common experience for a person 75 or 80 years old to have peritonitis and yet complain very little, and even refuse to be admitted to the hospital.

What information is to be gained from the laboratory data? The man was perspiring profusely and receiving no fluids by mouth. We would expect him to be dehydrated, and therefore his blood should show a hemoconcentration, which it did, with a red blood count of 7 million and with 18 Gm. of hemoglobin. The white blood count, despite a probable peritonitis, was only 5700.

Although attention should be paid to the total white cell count, experience indicates that the clinical evaluation of the patient is more valuable. We have seen a number of patients with a white cell count of 5000 who had a generalized peritonitis. When the patient is acutely ill, as this man was, the diagnosis must be made and the treatment planned and administered immediately without relying on the laboratory data. It often takes time to get the laboratory data. Furthermore, many practitioners do not have it available and must be able to make a clinical diagnosis without the aid of the laboratory.

THE HISTORY

The history of abdominal distention, constipation, nausea and vomiting are consistent with the diagnosis of cancer of the left colon, with large bowel obstruction, probably of the sigmoid region. It may be that the so-called "flu" was in reality a manifestation of subacute intestinal obstruction, producing vague abdominal uneasiness and discomfort. In some cases of obstruction of the left colon, the large bowel proximal to the obstruction becomes tremendously distended. If the ileocecal valve is competent, this distention may become so great that the blood supply of the cecum is interfered with and a localized area of gangrene in the region of the cecum occurs. This would explain the appearance of a generalized peritonitis.

Secondly, did the patient not have appendicitis? This may be more likely than obstruction by carcinoma. There is no evidence here of a previous operation, and the age of the patient is not significant. Certainly we should have to say that it is very possible. His symptoms would depend upon the location of the appendix. The classical symptoms of abdominal distress, nausea and vomiting, and right lower quadrant pain may be found with inflamed appendices located medial to the cecum. However, the appendix may be retrocecal or along the lateral cecal wall, so that the abdominal distress simmers along slowly, the omentum is not able to wall off the infection completely, and peritonitis results. It would be a reasonable assumption that he could have had appendicitis with perforation and peritonitis.

Acute cholecystitis with a free perforation, or acute pancreatitis should be considered. There is little evidence either in the history or from the physical examination to suggest the biliary tract as the etiological factor. However, there is some laboratory evidence to support the diagnosis of acute pancreatitis. Although the blood amylase level was within normal limits at the time of admission, a high amylase level (2000 units) was found in the fluid aspirated from the peritoneal cavity. Acute hemorrhagic pancreatitis might produce the clinical course demonstrated by this patient.

BLOOD AMYLASE

We know that the blood amylase level may not be elevated in cases of acute pancreatitis for longer than 48 to 72 hours after the onset, and cannot be depended upon as a diagnostic aid after such an interval of time. However, the peritoneal fluid in such cases may show a high amylase level for a much longer period of time. This is not entirely reliable, as shown by Dr. Robert McCleery[1] in this clinic. The amylase level in the peritoneal fluid may be elevated, unfortunately, in the presence of gangrenous small intestine or in the presence of a perforated duodenal ulcer. Acute pancreatitis is not a rare condition, as we have learned, since blood amylase determinations have been routinely made in all patients complaining of acute upper abdominal pain. If this diagnosis is made, it is good judgment to defer surgical intervention and rely on the usual supportive measures.

Perhaps he could have had a volvulus of the sigmoid colon with gangrene of the intestine and subsequent peritonitis. Volvulus is usually listed among the possible causes of intestinal obstruction in elderly males, but it is rare in my clinical experience. If this patient had been an elderly woman, I would have considered the possibility of a strangulated femoral hernia. They are very treacherous. Elderly females commonly have just this syndrome of nausea, vomiting and abdominal distention from a small strangulated femoral hernia. Such a hernia may be so small as to escape the casual examiner.

Could it be a diverticulitis? It is a common cause of peritoneal inflammation in the elderly patient. You would expect to find a localized abscess rather than a generalized peritonitis, and for that reason I am inclined to dismiss diverticulitis as a possibility.

We must consider the evidence presented in this case in favor of a perforation of a carcinoma or ulceration of the gastrointestinal tract. It would be very unusual for a man of this age with an apparently negative past history for ulcer to have a perforation of a duodenal ulcer. If his peritonitis is due to a free perforation of the

upper gastrointestinal tract I would favor the diagnosis of gastric ulcer or gastric carcinoma rather than duodenal ulcer.

Mesenteric thrombosis might be considered, but he would not have survived for 12 days after the onset. This lesion may produce symptoms of mild intestinal obstruction, but the course is rapidly downhill. This man had very little morphine after he was in the hospital. We don't know how much he had had originally, but he certainly should require more than he had if mesenteric thrombosis was present.

It seems to me that all we can say is that he had peritonitis from one of the causes previously mentioned. What should have been done about it? He certainly was in no condition to withstand a surgical procedure. He came into the hospital with a subnormal temperature, a respiratory rate that fluctuated from 50 down to 30 and 40, and obviously in shock. That should mean something; either pneumonia, heart failure, blood loss, or toxemia from peritonitis. Certainly it was an alarming situation.

THE BLOOD PRESSURE

The pulse rate in spite of the hospital treatment never fell below 120. The immediate problem was to combat shock and attempt to diagnose his condition. He was given 10 and 20 per cent glucose in distilled water in the amount of about 2000 cc. a day, and yet no beneficial effect was noted in the pulse rate. Instead of trying to raise the blood pressure with intravenous fluids, it might have been better to wrap the arms and legs to support the circulation.

Of course fluids are required, but in the presence of shock the repeated administration of the crystalloids may be dangerous. Since the pulse rate was not charted as ever coming down, I should think that this man needed plasma and whole blood, and this would have had a beneficial effect on the pulse rate. Certainly they are indicated in the presence of peritonitis.

Finally, I believe that larger doses of penicillin are advisable in the presence of peritonitis. The routine use of 50,000 units every three hours might have been increased to 100,000 units every two hours. There is considerable evidence in the literature to support this large dosage.

CLINICAL DIAGNOSIS

Generalized peritonitis due to:

(1) probable carcinoma of the left colon with large bowel obstruction:

(2) possible acute appendicitis with rupture;

(3) possible pancreatitis;

(4) possible perforated gastric ulcer or gastric carcinoma.

GENERAL CLINICAL DISCUSSION

Dr. J. L. Morton: The x-ray films showed no signs of intestinal obstruction. The diaphragm was slightly elevated on the right. The film on the left was interpreted as having air in the colon.

Dr. Zollinger: Do you think there were any signs of fluid levels?

Dr. Morton: We thought there might have been one.

Dr. Zollinger: Was there any evidence of pulmonary edema?

Dr. Morton: No. There was some evidence of bronchopneumonia. There were increased hilar markings and the heart seemed large. The patient was lying on his back and the film was very indistinct. It fit in very well, however, with peritonitis.

Dr. E. von Haam: What about surgery in this case?

Dr. Zollinger: I don't believe that it was ever warranted. It is foolish to subject a patient to surgery unless the supportive treatment overcomes the existing shock. This man never did recover from a state of shock. He appeared to be in the terminal stages of generalized peritonitis. After 12 days his chance of recovery would be better under conservative management than by surgical intervention. I am confident that this man had generalized peritonitis but I am at a loss to explain the responsible etiological factor.

PATHOLOGIC DIAGNOSIS

1. Carcinoma of pancreas with metastases to liver.
2. Duodenal ulcer with perforation and peritonitis.
3. Bronchopneumonia.

PATHOLOGIC DISCUSSION

Dr. von Haam: The assumption of Dr. Zollinger that the patient had peritonitis was correct. On opening the body a large amount of fibrinopurulent exudate was found in the peritoneal cavity. The pleural and pericardial cavities were normal. The heart and aorta showed no gross pathologic change. In the lungs we could confirm the presence of bronchopneumonia which Dr. Morton suspected from the roentgenogram. It was not very extensive but was definitely spreading. The spleen was small, such as is found in old people. We do not expect an enlargement of the spleen in the presence of peritonitis or in the presence of infections in older individuals. The liver was enlarged and showed metastatic nodules of carcinoma.

After breaking up the numerous recently formed fibrous and fibrinous adhesions which matted together the loops of bowel, an opening in the posterior wall of the duodenum became apparent, through which a large amount of chocolate-colored fluid exuded on pressure—apparently a perforation in the upper part of the

duodenum. This perforation may well explain the clinical finding of increased amylase in the peritoneal fluid. It is one of the other factors besides pancreatitis which lead to a rise in amylase level in the peritoneal fluid.

Opening of the duodenum revealed an ulcer, the bottom of which had perforated. The ulcer showed an elevated margin with thickening and increased firmness of the marginal zone. The perforation measured 5 mm. and was in the center of the ulcer. The adjacent peritoneum was the site of an intense suppurative inflammation which had begun to wall itself off from the rest of the abdominal cavity.

The pancreas was normal in weight. Its body and tail were largely replaced by a firm whitish-gray mass which was recognized as a malignant neoplasm. The liver showed metastatic involvement by the carcinomatous process. In the history no symptoms referable to this condition had been elicted. The ulcer was probably not older than a few weeks and any history of pain and discomfort extending farther back must have been caused by the malignant process in the pancreas.

The remaining part of the autopsy showed moderate atheromatosis of the abdominal aorta and a slight enlargement of the prostate.

MICROSCOPICAL FINDINGS

The microscopic study of the autopsy confirmed largely the gross findings. Section through the duodenal ulcer showed that it was a chronic peptic ulcer with the usual fibrosis, but that the bottom was formed by a broad area of necrosis and a relatively small zone of granulation tissue. The margin showed hyperplastic mucosa but no evidence of malignant change.

Section through the pancreas showed a carcinoma of the acinar type. This is not quite as common as adenocarcinoma arising from the ducts. Sections through the non-neoplastic parts of the pancreas showed that the patient had suffered previously from interstitial pancreatitis with periductal fibrosis and proliferation of the ductal epithelium, but the neoplasm arose in multiple foci from the acinar tissue. In fact, it bears some likeness to carcinoma arising from islet cells, but this likeness is not universal enough to make it a malignant islet cell tumor.

Carcinomas of this type arising in this area will produce no pancreatic insufficiency of any type unless they are very far advanced. The only symptom elicited is that of vague pain above the umbilicus. Decreasing pancreatic activity will then lead to anorexia, with loss of weight and cachexia.

The metastatic tumor in the liver was histologically similar to that in the pancreas.

In summary, we may state that this patient suffered from two unrelated conditions—a chronic one, carcinoma of the pancreas, which undoubtedly would have led to his certain death within months; and an acute one, a perforated ulcer of the duodenum, which was directly responsible for most, if not all, of his admitting symptoms and his death. An interesting fact in this case is that the amylase determination in the peritoneal fluid pointed to the pancreas as the site of the disease, overlooking the possibility of the escape of pancreatic juice through a duodenal perforation.

GENERAL DISCUSSION

DR. ZOLLINGER: Did the patient actually have bronchopneumonia or just edema from the failing circulation?

DR. VON HAAM: The pneumonia was more of the hypostatic variety. However, there was definite alveolar inflammation.

DR. ZOLLINGER: The thickened area in the duodenum was not a metastatic attachment between the liver and the duodenum and the hole a tear in the attempt to separate them?

DR. VON HAAM: The inside of the duodenum showed clearly that the hole was the perforation of an ulcer. From the size and shape of the ulcer one must assume that it had not been present for a long time and must have formed on the basis of a large erosion with rapid perforation. An acute perforating ulcer of the duodenum is certainly unusual in a man of this age. It is more common in young women.

DR. ZOLLINGER: You are correct when you say that acute duodenal ulcer is very rare and difficult to diagnose in the aged. It occurs much more frequently in young individuals, as pointed out. In cancer of the body of the pancreas, individuals complain often of being nervous and are diagnosed for a long time as cases of gastrointestinal neurosis with back pain and vague discomfort until the disease has so progressed that more definite symptoms arise and the true diagnosis can be made.

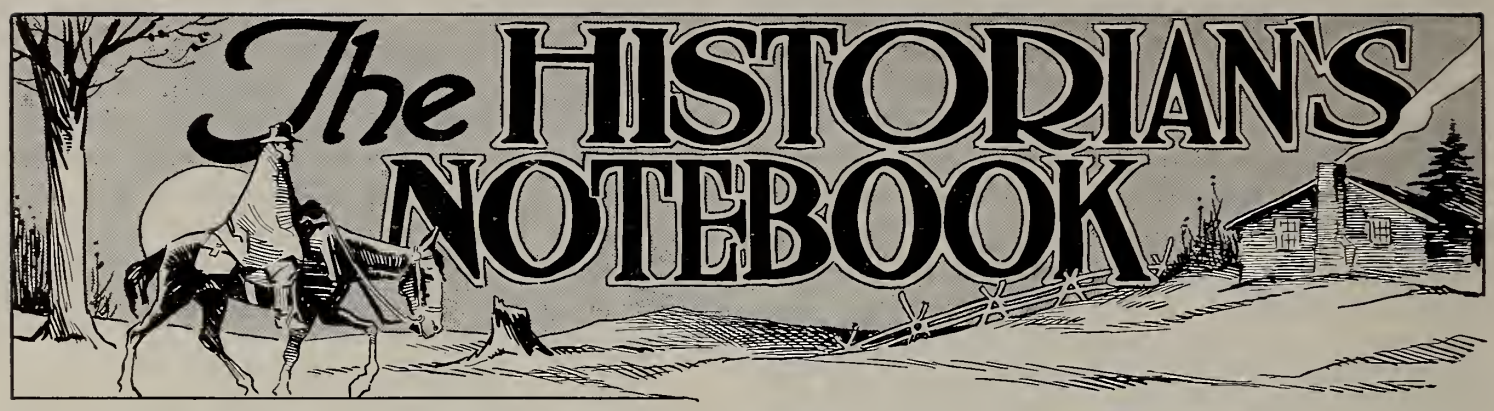
REFERENCE

Keith, L. M., Jr., Zollinger, R. M., and McCleery, R. S.: Peritoneal Fluid Amylase Determinations as an Aid in the Diagnosis of Acute Pancreatitis. Arch. Surg., 61:930-936, 1950.

Penicillin Anaphylaxis

Fatal consequences following the complications due to sensitivity to penicillin are reported by Siegal. While such serious reactions are not frequent, they do occur and it must be remembered that their infrequency does not make death itself any the less tragic.

This remarkable drug, penicillin, with its outstanding record of usefulness, furnishes a most noteworthy example of the author's statement that any drug may have a Jekyll-Hyde personality. The drug is positively outside the category of normal physiologic substances and is therefore a foreign material.—A. L. Tatum, M. D., Madison: *Wisconsin M. J.*, 52:417, July, 1953.



Dedication of Plaque Memorializing the Physicians In the Indian Wars*

By PAUL A. DAVIS, M. D.
President of the Ohio State Medical Association

IT is with a great deal of pleasure that I have the honor to present to the Ohio Archaeological and Historical Society on behalf of the Ohio State Medical Association, this plaque dedicated to those physicians who accompanied the Federal Forces and the State Militia to the Western country.

They came here in an effort to make the West safe for the soldiers of the Revolutionary War to take up their bonus military lands for settlement, and to permit the various Eastern land companies to develop their Ohio holdings.

We Ohio physicians want to pay tribute to those of our profession who served with the United States troops in the Indian wars. They left their comfortable and safe homes back East to serve their country in a wilderness. They came also seeking adventure and a knowledge of the Western country—often, it is true, with the thought of settling there themselves when the land had been made safe from the Indians and British intrigue.

They suffered and risked their very lives for their country in keeping with the best traditions of our profession. Whether they died of disease, were killed in battle or lived to return to peaceful pursuits, they were all true followers of Hippocrates.

HISTORY REPEATS

"History has a way of repeating itself," is a trite saying but nevertheless a true one, for as Cicero said centuries ago, "He who does not know what has taken place in the past, must remain forever a child." It therefore behooves us Americans to pay more attention to the history of our Republic.

In this connection there is a strange analogy between the situation in which the United States found itself after the Revolution and the situation today. In 1786 our young Republic was facing trouble in the West with the Indians and the Spanish, and more particularly with the British. The British in Canada had taken over the interests of the French in trading with the Indians. Their interests, therefore, were opposed to the settlement of this Western country and were coincident with the hunting and trapping skills of the Indians. The Spanish were touchy about trespass on their lands and trade on the Mississippi River.

So, the British were supplying the "reds" with firearms, ammunition, and assurances of cooperation, much as Russia is doing for the Chinese "reds" today. The main concern of the government in Washington then, as now, was how to avoid a war with one of these great powers.

After the rout at Fallen Timbers General Wayne was under wraps not to attack the British fort which was, in fact, the base of supplies for the Indians—reminiscent of McArthur's order in Korea. This appeasement policy did postpone the inevitable war with England for 26 years. Appeasement can at times postpone a war but does not insure against the certainty of war.

UNFAIR TO DOCTORS

Lay historians writing of those early days are inclined to make light of the knowledge and skill of the military surgeons. This is most unfair and comes about through a misunderstanding of the history of medicine. These men had at their

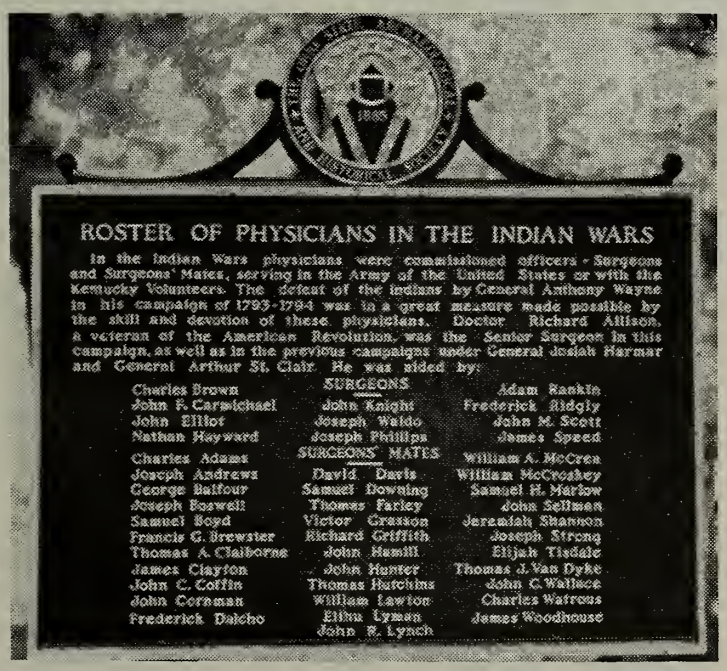
*Address delivered July 4, 1953, on the site of Fort St. Clair, at Eaton, dedicating a plaque in honor of physicians who took part in the Indian Wars. The marker, erected by the Ohio State Medical Association working in collaboration with the Ohio Archaeological and Historical Society, was a contribution to the celebration of the Sesquicentennial of Ohio's Statehood.

disposal, and they did apply to the care of the sick and the wounded, all of the empirical knowledge of the ages for as yet there was no knowledge based upon experimentation available.

Today, on the other hand, medicine practices an art. The physician uses that which the applied scientists dealing in Pathology, Bacteriology, Immunology and Biochemistry have taught him. None of these sciences even existed in the days of the Indian wars.

It was not until the Mexican War that our military surgeons had medicines whose active principles they could identify and thus make sure of the potentialities of their organic drugs. In the War Between the States they had anesthetics to relieve pain but no antiseptics to prevent infection—in fact, no knowledge of the evidence of bacteria. As a result typhoid fever and other infectious diseases killed more soldiers than did the bullets of the enemy. A similar situation presented itself in the Spanish-American War. Out of this war, however, did come the discovery of the cause of yellow fever by Walter Reed.

In the Boer War the British introduced vaccination against typhoid and paratyphoid infection. With this development of immunology it became possible to mobilize millions of men under arms



Roster of Physicians in the Indian Wars, as shown on one side of the marker erected in their memory by the Ohio State Medical Association.

with much less danger from sickness. Bullets, shrapnel, and poison gas from the enemy, became the real risk of World War I instead of disease.

With the Second World War came the use of whole blood, plasma, the miracle drugs, and immediate evacuation by air to base hospitals. The death rate from wounds fell to an almost unbelievably low level. Just as these military surgeons of the Indian wars, whose memory we honor today, used that which science gave them to work with, so our profession has stood ready in every genuine war to give to our country's Armed Forces the best that our scientific knowledge of the day will permit.

THE PATRIOTISM OF DOCTORS

The long roster of Ohio physicians who have served our country to the fullest of their capacities from the days of the Northwest Territory to the present day proves the patriotism of the members of our profession.

With this thought in mind the Ohio State Medical Association does honor to itself in erecting this memorial plaque on the historic site in memory of the members of our profession who served at a time when the medical corps of the Army had not yet been organized and the quality of medical care of the troops depended largely upon the individual surgeon's skill. Their supplies were meager, soil and weather conditions were unfavorable, epidemics were frequent, and knowledge of military medicines were perfunctory.

It is my privilege in the name of the Ohio State Medical Association to turn over to the care of the Ohio Archaeological and Historical Society this plaque in the memory of the physicians who served with the Armed Forces of our country in the Indian wars.

Pioneer Physician Is Honored In Trumbull County

The Trumbull County Medical Society's contribution to the Ohio Sesquicentennial Celebration was the following biographical sketch memorializing the first resident physician of that area. The sketch, written by Dr. James J. Tyler, chairman of the T. C. M. S. Sesquicentennial Committee, was published in pamphlet form by the Society. Further honor was rendered by a pilgrimage to the burial plot in a hillside cemetery on the Niles-Cortland Road, near Howland, and placing of a wreath by members of the Society on June 28. Dr. Tyler's comments on Dr. Seely were as follows:

DR. JOHN WILLIAMSON SEELY

Dr. John Williamson Seely (1771-1840) was the first resident physician in the present Trumbull County, Ohio. He was the son of Silvanus and Jane (Williamson) Seely. His father served in the Revolutionary War from the state of New Jersey and later removed to the state of Pennsylvania.

In the year 1806, Dr. John W. Seely of Jefferson, Green County, Pennsylvania, located in Howland Township, Trumbull County, where he cleared a farm and in the following year removed his family to the new location. The house which he built on his farm in Howland Township is still standing. It is said to have been three years in the course of construction and was built from seasoned timbers obtained from trees on his farm.

He was at one time the owner of the celebrated

"Howland Springs," which after it had changed hands several times was purchased by the Shedd Brothers of Youngstown in 1876. An account of that year states that "the grounds have been improved and beautified until they are at present one of the most pleasant Summer resorts in the State, and the medicinal qualities of the water bring a large number of health-seekers. Convenient buildings and accommodations have been provided for the comfort and entertainment of the visitors. The water has been analyzed by competent chemists, and pronounced to be equal to any in the country in health giving qualities."

MEDICAL DISTRICTS

Under a law enacted by the General Assembly of Ohio and effective Feb. 8, 1812, the counties of the state were divided into seven medical districts. A place of meeting in each district was also specified by the law. The Sixth District comprised the counties of Trumbull, Geauga, Portage, Ashtabula, Cuyahoga and Huron. The physicians of this district were directed to meet in Warren on the first Monday in June, for organization as a society and the election of officers and delegates to a convention to be held at Chillicothe in the following November.

The only remaining record of this early meeting is found in the second issue of the first newspaper of the Western Reserve, the *Trump of Fame,* published at Warren, June 16, 1812, in which it is stated that "in conformity to the laws of the state of Ohio, regulating the practice of physic and surgery, a number of the members of the Medical Society of the Sixth District, convened at Warren, Trumbull County, Ohio, on Monday, the first day of June, when—Dr. John W. Seely of Howland was chosen chairman; Dr. David Long of Cleveland, secretary and Dr. Shadrack Bostwick of Canfield, treasurer. Dr. Charles Dutton of Youngstown; Dr. Peter Allen of Kinsman; and Dr. Joseph DeWolfe of Ravenna were elected delegates to the convention to be held at Chillicothe.



House built by Dr. Seely, still standing near Howland.

For many years Dr. Seely continued to preside over the district and his ride—on horseback and with saddle bags—included the village of Warren. He was a large, portly man of light complexion, full of fun and a good story teller. As a physician he stood well in his day and for many years had a large practice.

WAR OF 1812

In the War of 1812, Dr. Seely attained the rank of general and also filled the positions of state representative in 1807 and state senator in the term of 1816-17. He was an earnest promotor of the Pennsylvania and Ohio canal and when the first packet boat arrived at Warren, May 23, 1839, a general holiday was declared. In the afternoon a banquet was held at Benjamine Towne's hotel at which Dr. Seely served as toastmaster. On completion of the canal to Akron, where it connected with the Ohio canal, another celebration took place.

Dr. Seely was a leading spirit of the Warren delegation, until he was suddenly seized with apoplexy. He is buried in an obscure hillside cemetery on a part of the farm he originally owned. His monument inscription reads: "Memorial to John W. Seely, M. D., who died August 7, 1840, in the 69th year of his age. Suddenly it came and left few moments agonizing pangs for those he loved so well." His wife Elizabeth (Williams) Seely died in 1845 and is buried beside him.

His son, Dr. Sylvanus Seely (1795-1849) followed his father in the practice of medicine and located in Warren, where he was a contemporary of Dr. John B. Harmon, Warren's first resident physician. Joseph G. Butler, Jr., of Youngstown, was a great-great-great grandson of Dr. John W. Seely. Of Mr. Butler it has been said that "of special note among monuments to his energy and persistence are the National McKinley Birthplace Memorial at Niles and the splendid art gallery which he erected for Youngstown."

Why Medical Experts Disagree

To gather facts and to interpret them truthfully is no easy task; for it requires time, patience and persistence to read what Plato calls the "long and difficult language of facts."—John E. Donley, M. D.: *Rhode Island M. J.,* 36:436, August, 1953.

A History of The Texas Medical Association 1853-1953, by Pat Ireland Nixon, M. D., ($6.00. *University of Texas Press, Austin, Texas).* From this Association which began the publication of its Journal coincidental with this Journal, comes now an excellent story of its existence since the beginning.

Enough Medical Officers Now . . .

Military Indicates Inductions May Be Called Off for Twelve Months; A.M.A. Charges Too Many Commissioned; Bad Effects Summarized

UNLESS there is a radical change for the worse in world-wide conditions, it is not expected that there will be additional calls for physicians placed against the Selective Service System by the President under the Doctors Draft Act for the next twelve months.

Moreover, many physicians who were recently commissioned as medical officers may not be called to active duty for months because of the decreasing need for medical officers, due to a combination of circumstances.

NATIONAL BULLETIN

The National Advisory Committee to Selective Service in a bulletin issued September 2 explained the situation with respect to Selective Service calls as follows:

"As a result of Call No. 16 in August and the increased number of volunteers, there have been commissioned a sufficient number of physicians to meet the needs of the armed forces for the immediate future. Those who have been commissioned from either the voluntary list or the Selective Service Call will be brought to active duty from time to time until this reservoir is exhausted."

WARNING ISSUED

However, the bulletin threw out a warning to hospitals, medical institutions and communities, as well as physicians who are most liable for military duty in event calls are resumed. It stated:

"Public Law 84 specifically designates that the Committee give advice in regard to residents, teachers, and research workers. As you know, this is a lull year and it will be necessary to watch situations in communities, medical schools, hospitals, etc., so that when calls are re-established we will find only, as an unusual exception, any of those who are liable, in essential positions."

OHIO COMMITTEE STILL FUNCTIONING

Dr. Drew L. Davies, chairman of the Ohio Advisory Committee, 79 East State Street, Columbus, in commenting on this new development said:

"Our committee will continue to function as in the past in close conjunction with the local advisory committees. We will continue to supply information to physicians and institutions on this question. We will continue with our work of compiling data on physicians, assisting the Selective Service in classifying them in case calls are resumed, and in advising physicians, institutions, hospitals, medical schools, etc., on future developments. Our committee hopes that medical schools, hospitals, and others, will heed the warning o the national committee and try to place in key positions those who are military-exempt or who can be easily replaced when and if Selective Service calls are resumed."

A. M. A. CHARGES WASTE

Almost at the same time, the official bulletin announcing that no additional physicians would be commissioned for some time was issued, the American Medical Association published a statement pointing out that the armed forces now have an excess number of doctors. In an editorial published in the September 5 issue of *The Journal of the A. M. A.*, the association criticized the Selective Service System for refusing to cancel its August call and pointed out that the results of commissioning an excessive number of medical officers will be:

BAD EFFECTS CITED

1. A wastage of medical manpower resulting in a reduction in the number of physicians available to care for the civilian population.
2. A tendency to use excess medical officers on nonmilitary assignments.
3. A squandering of available medical registrants under the "Doctor-Draft law" which would accelerate the call-up of doctors in priorities 3 and 4.
4. An inefficient utilization of physicians in uniform, with a resulting lowering of morale and general dissatisfaction with military service.
5. A nullification of the newly established ratio of 3.0 per thousand between medical and overall troup strength.

As recently as July 1 of this year, the editorial pointed out, it was the stated opinion of officials of the Department of Defense that the requirements of the Army for medical officers could not be met without recourse to a medical draft call by the Selective Service System.

MANY VOLUNTEERS

"A request for 524 physicians was officially made by the Secretary of Defense to the Director of the Selective Service System, who acted immediately to effect the call-up of these physicians through state and local Selective Service agencies," the editorial stated. "Shortly thereafter, a flood of applications for reserve commissions and active duty orders was received from physicians primarily in priorities 1 and 2 who had

previously been temporarily deferred for reasons of essentiality and to complete internship and residency training. These volunteers now exceed 1,200, a number far in excess of the present medical requirements of all of the branches of the armed forces combined.

"The termination of hostilities in Korea, a decision on the part of certain medical officers to extend their current tour of military duty until 24 months of service is completed, and the reduction in the ratio of physicians to troop strength ordered by the Secretary of Defense all served to increase the surplus.

REFUSED TO CANCEL CALL

"Notwithstanding this excess of medical officers, the Selective Service System refused to cancel its pending draft call, which forced 524 additional doctors to accept reserve commissions and apply for immediate active duty or be drafted as privates by August 28.

"The Army has announced that no more applications for commissions will be accepted after September 1 and is frantically urging its excess reservists to delay their requests for active duty for as much as one year. Even those who are insisting that they be called immediately cannot be placed in training classes until November or December at the earliest.

"It appears to be certain not only that the current draft call was unnecessary but that there will be no more such calls for many, many months to come."

As a result of this situation, many physicians and local communities will be seriously inconvenienced, the editorial said, adding:

CONFUSION HAS RESULTED

"Acting in good faith and on the basis of the assertions by officials in Washington that medical personnel was sorely needed, many of these men have closed their offices or have discontinued their plans for additional residency or postgraduate training. In many instances this discontinuance of training was forced on them because of the prohibition that prevented hospitals from accepting priority 1 and 2 men to fill available residency vacancies.

"Having terminated their civilian commitments on the assumption that they were needed immediately by the armed forces, these physicians are now faced with the prospect of an indefinite status for the next year or more. Possibly it is still not too late for many of them to change their plans, to request a delay in call to active duty, and resume their civilian occupations.

"The government officials charged with the administration of the 'Doctor-Draft law' are obligated to call to active duty only those physicians who are needed and immediately to advise medical reservists as well as Selective Service medical registrants when they can expect to be called for military service."

NEW RULES ON RESIGNATIONS

As a result of widespread criticism of their policies of not permitting regular medical officers to resign their commissions, thus discouraging physicians from making military medicine a career—described as a "captive" policy by some critics—, the Army and Navy have relaxed their regulations.

ARMY POLICY

Regular officers of the Army Medical Service may resign and leave the service under a new and more liberal Department of the Army policy, Major General Silas B. Hays, Acting Surgeon General of the Army, announced August 24.

Beginning with officers having the longest periods of service, a number will be allowed to resign each month, upon recommendation of The Surgeon General, provided they have met with certain service requirements. Previously, resignations were accepted only in cases of extreme hardship.

According to the new policy, regular officers who have no obligatory commitments to the Army and have served in the Regular Army for a period of three years are eligible for release. However, if they have served for less than eight years, they must accept commissions in the Reserve.

"Even though we expect to lose some officers in the next few months," General Hays said, "we believe the new policy will encourage physicians to enter the Regular Army because they will no longer feel that they will be committing themselves to an indefinite term of service. Actually, I believe that an increasing percentage of officers will find the military service so professionally stimulating and so pleasant that they will make it their career," General Hays concluded.

NAVY POLICY

About the same time, the Navy announced a new policy aimed at making a career in Navy medicine more attractive to young doctors. It would work this way: Resignations will be accepted from medical and dental corps officers who are initially appointed as lieutenants (j. g.) or lieutenants on or after August 7, 1953, and who thereafter serve in the regular component of their corps on active duty for four years. The Navy's chief of personnel comments: "This policy will free young medical and dental corps officers from the feeling that they are captives." In computing four years service, any time spent in internship, residency or other postgraduate training or any period of obligated service acquired through such training won't be counted.

Policy on resignations of physicians and dentists who entered the regular naval service before August 7, 1953, remains unchanged for the time

SOME VERY EXCELLENT POSTGRADUATE PROGRAMS ARE SCHEDULED BY DISTRICT AND OTHER ORGANIZATIONS FOR OHIOANS

Attention is called to the excellent selection of postgraduate courses sponsored by district organizations, institutions and other groups this fall. Some of these programs have already been held; but others are still in the future. Please refer to the September issue for details on the following programs:

October 14—Northwestern Ohio Medical Association, Toledo.

October 28—Sixth Councilor District Meeting, Canton.

November 5-7—Saint Luke's Hospital Symposium, Cleveland.

November 11—Ohio and Western Pennsylvania Regional Meeting, American Rheumatism Association, Akron.

December 3—Cancer Symposium, Youngstown.

In this issue are details on a course offered October 28-29 by the Bunts Institute of the Cleveland Clinic.

being. Resignations are considered on an individual basis, depending on data listed in the resignation request; hardship is one of the major considerations. Bureau of Naval Personnel currently is studying new resignation criteria for this group, with the possibility of establishing a more definite policy.

The office of Dr. Melvin Casberg, Assistant Secretary of Defense for Medical Matters, reassures those draft-eligible doctors alerted by Selective Service but not actually ordered to duty that they may have more time than they think. A spokesman for Dr. Casberg emphasized that there often is a long delay between receipt of individual letters informing the physicians they will be called and their actual orders carrying the date to report.

Most of the men involved want to postpone closing out their practice or making other personal arrangements until they receive more definite word as to when they must leave civilian life. That definite word, according to the Assistant Secretary's office, comes with the orders which specify a particular date. A minimum of 30 days is provided between receipt of the order and the date for reporting for duty. In many cases, a much longer period is allowed.

Dr. Rodman Wilson, resident physician at Cincinnati General Hospital, has been named temporary director of an expanded industrial medical program for the Gardner Board and Carton Company, Middletown. The move is the first step in a long-range medical program for the company.

The Association of State and Territorial Health Officers will meet in the Washington Hotel, Washington, D. C., November 4-7. Dr. John D. Porterfield, director of the Ohio Department of Health, Columbus, is secretary.

Army Wins First Round In Legal Fight About Doctor Draft Law

In the first legal contest under the newly amended doctor draft law, a Federal district court judge ruled that the law passed by Congress last June does not make it mandatory for the armed services to commission a physician or dentist called up under the amendment. On a second issue of whether the Army must, therefore, give the doctor a discharge when he requests it, the question was not as clear cut. The judge held the petitioner (a 37-year-old dentist) had not contended he was inducted or being held in service unlawfully. The case, which is expected to be appealed, was heard in an Alexandria (Va.) court before Judge Albert V. Bryan.

The dentist, Dr. Herbert L. Nelson, was inducted May 28. On two occasions in filling out applications for commission he declined to state whether he had been a communist or a member of a communist organization.

Subsequently, according to further testimony, he filed a statement admitting membership in the Young Communist League while in college and later in the International Workers Order. The Army informed the court that upon completion of basic training, Dr. Nelson would practice dentistry in the Army, probably at Fort Lee, Va., but that he wouldn't be commissioned nor allowed to handle any restricted or confidential material.

Attorney for Dr. Nelson argued that if his client is to be retained on duty, then the Army is required to commission him in light of the new amendment. It states a physician or dentist "shall, under regulations prescribed by the President, be appointed, reappointed, or promoted to such grade or rank as may be commensurate with his professional education, experience, or ability." The court did not agree. The petition for a writ of habeas corpus was denied.

Election Day Issues . . .

Digest of Provisions of Nine Proposed Amendments to Constitution Which Will Be Voted On at the General Election, Tuesday, November 3

OHIO voters will have the opportunity on Election Day, Tuesday, November 3, to vote for or against nine proposed amendments to the Constitution of Ohio. The proposals will be on the "Questions and Issues" ballot as a result of joint resolutions adopted by over the required three-fifths vote of both houses during the recent session of the Ohio General Assembly. Amendments to the constitution must have the approval of a majority of those voting on each issue.

Believing that physicians as citizens, taxpayers and voters should be informed on these issues, *The Journal* offers the following brief description of the questions involved and urges its readers to go to the polls and vote their convictions on Election Day.

The proposed amendments will appear on the ballot numbered 1 through 9. (No. 1 authorizes a $500 million bond issue for "adequate highways." No. 2 provides for a state board of education.) The seven remaining proposals would repeal or amend obsolete sections of the constitution.

BOND ISSUE

No. 1. Bond Issue for Highways. Proposing to amend Article VII of the Constitution of the State of Ohio to authorize the issuance of revenue bonds up to $500 million dollars, the proceeds thereof to be used to provide adequate highways.

Briefly, here are some of the arguments used by the proponents of the "adequate highways" amendment in urging a favorable vote on Nov. 3:

The Legislature has provided the money for needed improvements to Ohio's highways through increased taxes on gasoline and trucks. Voters have their choice of spreading this new construction over 20 years under the present system, or getting it done in half the time with a bond issue. Passage of the bond issue will not require more taxes on real estate or anything else. Existing revenues will be used to finance the bonds.

Financial experts who have made a close study of the Ohio proposal have stated that the cost of interest on the bonds will be more than offset by savings on stop-gap repairs which would be needed to keep roads usable if new construction is delayed a decade.

More than half the states use the revenue bond system for highway improvements—thus not putting off until tomorrow things that need to be done today. There is nothing new about this. There would be no modern public schools without bond issues. Most homes, churches and hospitals are built by borrowing money in anticipation of future funds. So, why not get roads when we need them, in the very same way?

A favorable vote on the bond issue will not be like signing a blank check. On approval of the amendment, the Legislature will hold a special session next January to get the program under way. Every appropriation will still be made by the Legislature on the basis of proposals submitted in advance by the Governor and highway officials, with opportunity for the public to be heard in committee hearings.

The amendment also provides these restrictions: No more than $125,000,000 can be authorized in one year. No part of the debt can be contracted after March 31, 1962. Bonds must be so issued as to retire the whole debt by 1972. Money can be spent only on major thoroughfares. All construction must be by contract.

The Ohio State Automobile Association is taking the lead in lining up favorable votes for the highway bond issue, and it will undoubtedly have the support of many groups representing "highway users."

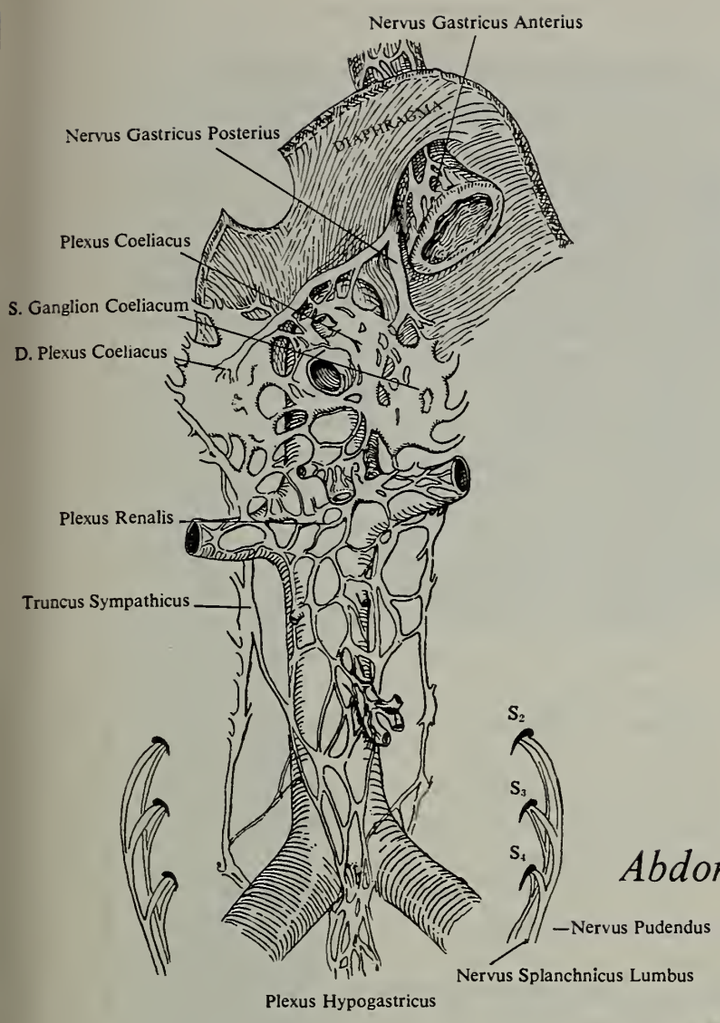
BOARD OF EDUCATION

No. 2. State Board of Education. Proposing to amend section 4 of Article VI, to create a state board of education with power to appoint a superintendent of public instruction, and to abolish the existing office of superintendent of public instruction appointed by the governor.

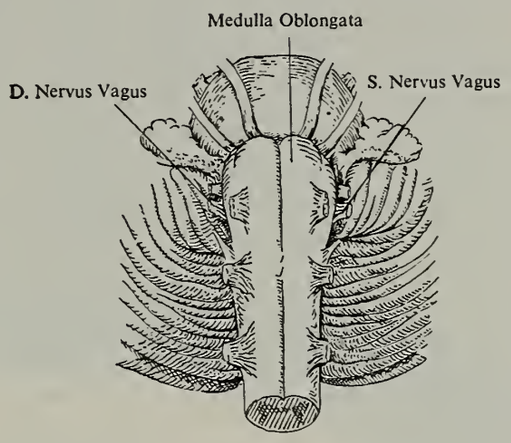
At present the state director of education is an appointee of the governor, for a four-year term. In Ohio's parade of state superintendents only two have served more than a single term. Proponents of the State Board amendment believe that long-range planning cannot be realized during such transient service. They contend that since the responsibilities and decisions thrust upon the state's chief school officer are tremendous and of far-reaching importance, he should have the counsel and backing of a group of qualified citizens, just as the head of a large corporation has the benefit of and prestige of a board of directors.

It also is pointed out that the present situation at the state level, if applied locally, would mean the appointment of the school superintendent by the mayor, rather than by a board of education. Given as a major reason for a state board is that it would be more representative of the wishes of the people.

In the opinion of legislators who sponsored the state board proposal, details for determining



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Abdominal autonomic plexus (sympathetic)

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It has been shown[1] to diminish gastric motility and secretion significantly as well as intestinal and colonic motility.

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Banthīne® (brand of methantheline bromide) is supplied in: Banthīne ampuls, 50 mg.—Banthīne tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthīne) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

SEARLE Research in the Service of Medicine

the number, length of term and method of selection of members should be worked out after the voters have decided whether or not they want such a board. If such provisions are made by law, rather than written into the constitution, changes required by future needs can be made without again attempting to amend the constitution. If the voters decide on November 3 that they want a state board of education, it will be the responsibility of their representatives in the General Assembly to find out what type of board will be most suitable for Ohio and then pass appropriate laws to get it established.

Forty-two states now have state boards of education. Sixteen have boards which appoint the state superintendent. Eight of those 16 have switched to a state board since 1940. Such state organizations as the Ohio Congress of Parents and Teachers and the Ohio Education Association have long advocated creation of a state board of education in Ohio.

OTHER PROPOSALS

Seven other proposed constitutional amendments Nos. 3 to 9 inclusive repeal or correct obsolete sections of the Constitution. At the recent session of the Ohio General Assembly a special Joint Legislative Committee was created to study and report back recommendations for constitutional amendments to weed out obsolete, outmoded and impractical sections of the state's organic law. The Ohio Code Revision Commission also cooperated in the study, which resulted in a recommendation, concurred in by the Legislature, that the voters be given an opportunity on November 3 to repeal certain "deadwood" sections of Ohio's constitution. The amendments would do the following:

3. Eliminate word "white" from reference in constitution to militia duty.
4. Repeal provisions for election of officers of the militia.
5. Correct conflicts between Ohio and United States constitutions on ratification of amendments and election of U. S. senators.
6. Remove restrictions on eligibility of women to hold certain offices.
7. Repeal provisions for revision of proceedings of courts of record.
8. Repeal provisions relative to elected officials holding office in 1905.
9. Repeal provision for World War I bonus.

Index Medicus

The *Quarterly Cumulative Index Medicus*, volume 50, which covers the literature for the last half of 1951, is now off the press and available for purchase from the Order Department of the American Medical Association. The next volume is in production and should be completed by the end of the year.

Be Sure Signature Is Legible On Commission Blanks

When sending fee bills and forms to the Ohio Industrial Commission make sure that your signature is legible. Specifically, after signing the blank or fee bill in your own handwriting, have your name typed under the signature or use a rubber stamp, as some physicians are doing.

A physician who is a member of a group to which payment is to be made by the Commission may designate, by a rubber stamp or otherwise, that the payment is to be made to the group. Of course, the personal signature of the physician rendering the services must be affixed.

Commission officials say that many delays in payment of fee bills can be eliminated and payment to wrong physicians can be avoided if physicians will be sure their signature is legible. Use of a rubber stamp or typewriter, in addition to the handwritten signature, is strongly recommended by them.

Also, they point out that time and work by the Commission can be saved when payment is to be made to a group, rather than to an individual physician, if instruction to this effect is written on the form, either by typewriter or by use of a rubber stamp. In such cases, only one warrant will have to be issued by the Commission to cover multiple cases, instead of separate warrants on each case treated by each physician in the group. The signature of each physician rendering the services must appear on the blank but only one warrant covering fee bills submitted by all members of the group will be issued if the Commission is advised that payment may be made in that manner.

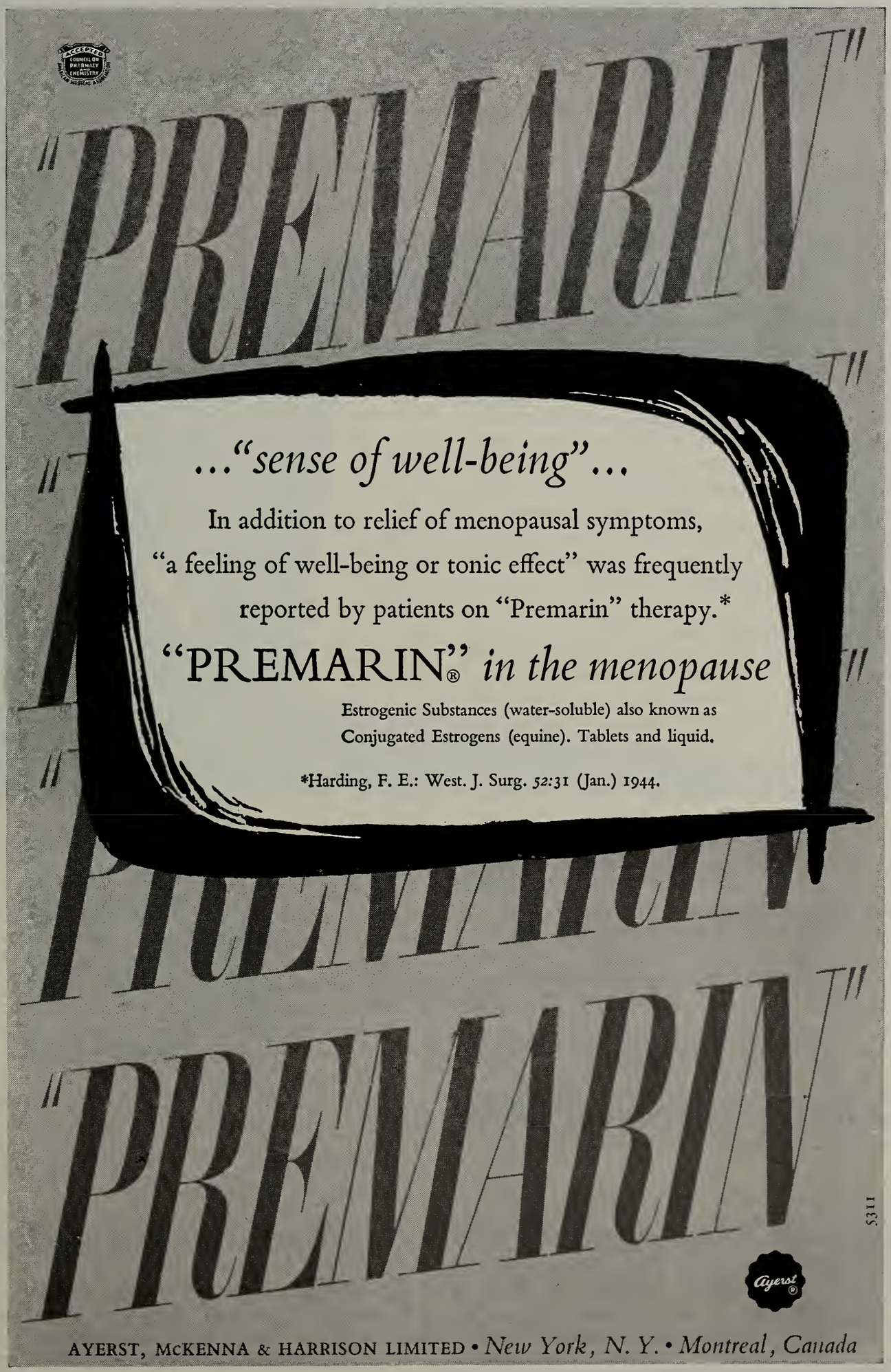
American Fracture Association To Meet in California

Two Ohio physicians are scheduled to take part in the program of the 14th annual meeting of the American Fracture Association to be held in the Mission Inn, Riverside, Calif., October 12-15.

Dr. C. L. Barrett, Bellefontaine, will speak on "Traumatic Neck, Head and Eye Syndrome in Cervical Fractures."

Dr. Henry A. Springer, Cincinnati, will speak on the subject, "The Use of Physiotherapy in Fractures."

Dr. H. W. Wellmering, 610 Griesheim Building, Bloomington, Ill., is secretary general of the organization.


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*Harding, F. E.: West. J. Surg. 52:31 (Jan.) 1944.
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Bricker Halts Probe . . .

Stops Study of So-Called Cancer Cures, Started by Late Sen. Tobey, After Charges Are Made Against A.M.A. and Pearson Gets into Act

SENATOR JOHN W. BRICKER, Ohio, wants no part of an organized move to propagandize so-called "cancer" cures and to discredit the American Medical Association's policy and activities in the field of research and in exposing treatments of questionable value.

Shortly after taking over the chairmanship of the U. S. Senate Interstate and Foreign Commerce Committee, succeeding the late Senator Charles W. Tobey, N. H., Senator Bricker found himself in the middle of a controversy in Chicago involving the drug Krebiozen; another cancer treatment—the Lincoln treatment—;the Senate committee; an investigator by the name of Benedict Fitzgerald; and Drew Pearson, the columnist.

Shortly before his death, Senator Tobey, an advocate of the Lincoln treatment, undertook a "confidential" investigation of Krebiozen. Tobey was mad at the A. M. A. for refusing to give its blessing to Lincoln's medicine.

When the Illinois State Legislature began its investigation of the Krebiozen controversy—involving the A. M. A. which had branded the drug of doubtful value—Tobey saw an opportunity to investigate cancer drugs, treatments and institutions, generally, and to find something which might make this a national issue.

Tobey borrowed Fitzgerald, a justice department lawyer, for the study. Fitzgerald completed a report about the time Senator Tobey died. He fed some of the material to Pearson. Pearson used it, as it contained wild statements and allegations concerning the A. M. A. Pearson intimated Bricker was "suppressing" the report.

After Pearson's public statement criticizing him and the A. M. A., Bricker went into action.

Following is the text of an interview on August 21 with Senator Bricker, published in the *Columbus Dispatch*, which fills in additional facts on the controversy and reveals Bricker's reasons for refusing to be a party to a questionable project under the guise of an official investigation and a slanderous attack on the A. M. A.:

* * *

Sen. John W. Bricker confirmed reports Friday that he would not authorize continuance of an investigation into cancer treatments started by the late Senator Charles W. Tobey.

Now chairman of the commerce committee which Tobey formerly headed, Bricker branded statements by Benedict Fitzgerald in an interim report of his investigation as "one man's opinion."

Fitzgerald's report supported use of the drug, "Krebiozen," and other drugs in cancer treatment.

It accused the American Medical Association and former A. M. A. officers of obstructing worthwhile cancer research and charged existence of a "conspiracy" to stop the free flow and use of drugs "which allegedly have solid therapeutic value."

At his home in Columbus, Bricker said Fitzgerald's four-month study was authorized by Senator Tobey alone and not revealed to the commerce committee. He confirmed the report that Fitzgerald's employment by the committee would be concluded the end of this month, and he added:

"I will have no part in any program that charges the A. M. A. with a conspiracy to prevent the control of cancer. I believe everything is being done that can be done."

Bricker said further any such investigation would not properly fall to the Senate Commerce Committee, anyhow, but would go to the labor and welfare committee if public health were involved or the judiciary committee if anti-trust charges were raised.

"However," he declared, "I don't know any reason for any such investigation. That's not our function in the Senate. We're not doctors or biochemists. If some angle of it developed that might affect the public as a whole, look toward legislation or show some conspiracy, then it would be a proper subject for investigation."

The Senator denied there had been any attempt "to suppress or reveal" contents of Fitzgerald's report. "When I took over the chairmanship, I wasn't aware he was doing it for Tobey," he said. "The report came to my desk just two days ago and went to all members of the committee. The study was not authorized by the committee or even taken up with the committee."

In the report, Fitzgerald called for a national investigation of the disputed Krebiozen, charged the A. M. A. with propagandizing remedies which "often do more harm than good," and branded the A. M. A. stand on the drug as "hasty, capricious, arbitrary and outright dishonest."

Dr. Edward J. McCormick of Toledo, A. M. A. president, fired back a charge last night that Fitzgerald's criticism contained "vicious lies."

He said in a statement from the Chicago headquarters of A. M. A. that Fitzgerald's accusations are "an obvious attempt to gain public recognition and support for an alleged cancer treatment whose continued promotion will result in thou-

50 YEARS AGO

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(1) Cheadle—*Artificial Feeding and Food Disorders of Infants*, Sixth Edition (1906)

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sands of cancer victims failing to seek and obtain proved therapy."

He said A. M. A. concluded on the basis of "careful scientific studies" that claims made for the drug were unfounded.

Fitzgerald in his report said Dr. Andrew C. Ivy, who had served on boards of the American Cancer Society and A. M. A. claimed "remarkable progress" in treatment of certain cancers with "Krebiozen" but pointed out that no favorable results had been shown in treatment of other types of cancer.

The report said the drug was originated by Dr. Stephen Durovic, who had been working with Dr. Ivy. Ivy was described as vice-president of the University of Illinois, now on leave because of controversy over the drug.

Fitzgerald, borrowed from the Justice Department, was carried on the committee payroll at an annual rate of $11,600 from May through August. He made some trips and oral reports to Tobey and Robert L'Heureux, committee counsel.

L'Heureux said Tobey decided not long before his death July 24 that the committee lacked jurisdiction for a formal investigation of the subject.

It was learned that Fitzgerald was recommended to Sen. Tobey by the Senator's son, Charles W. Tobey, Jr., Concord, N. H., attorney.

The Tobeys, father and son, were involved in another cancer treatment controversy several years ago. The younger Tobey said he had cancer and was treated in 1948 by Dr. Robert E. Lincoln of Medford, Mass. He said his father "waged a long fight" in the Senate to bring the treatment to the attention of medical circles.

* * *

BRICKER PRAISED FOR STAND

Did Senator Bricker do the right thing in calling off the investigation? The *Akron Beacon Journal* thinks he did and its views doubtless will be shared by many others who know the facts and the motives which prompted the investigation. Said the *Beacon Journal* editorially:

"The report which Drew Pearson writes about today was sent not only to all the members of the Senate Interstate and Foreign Commerce Committee, but also to the newspapers. The *Beacon Journal* received a copy of it yesterday —in an envelope bearing the frank of the late Sen. Charles W. Tobey of New Hampshire.

"After reading the 14-page document and the three-page 'press release' which accompanied it, we can understand why Sen. John W. Bricker of Ohio takes a dim view of this 'confidential report on cancer,' as Pearson calls it.

Author of the report is Benedict Fitzgerald, Jr., an attorney, who was commissioned by Senator Tobey—secretly, according to Pearson—to investigate the American Medical Association and its attitude toward cancer treatment.

"If the mission assigned to Fitzgerald was as the report describes it, what Senator Tobey wanted was corroboration of his own suspicion that the bulk of the medical profession has been engaged in a monstrous plot to condemn all cancer victims to certain death, either by killing them with x-ray, radium or surgery or by withholding lifesaving 'Krebiozen, Gloxylide, Mucorhicin and other drugs, preparations and remedies.'

"Fitzgerald writes with the fervor of a man who believes he has vindicated all of Senator Tobey's weird suspicions, but we note in the report a total absence of reliable documentation. The most dubious authorities—usually Fitzgerald himself—stand behind the savage criticisms of the A. M. A. and the testimonials to the various cancer 'cures' which the A. M. A. has denounced as frauds.

"The A. M. A., to its credit, has been critical of quacks who 'treat' cancer victims with worthless nostrums. It happens that Senator Tobey believed in some of these questionable 'remedies.' So, apparently, does Investigator Fitzgerald. But the Fitzgerald report is nothing but a hysterical diatribe against responsible medical authorities. Worse than that, the report invites cancer sufferers to build up false hopes in treatments that have been demonstrated as frauds.

"It is hardly to be wondered at that Senator Bricker, having succeeded Senator Tobey as chairman of the committee, declined to attach the committee's prestige to Fitzgerald's strange opinions.

"Fitzgerald is not the first committee staff member to release a report on his own authority. Rudolph Halley used to do it when he was counsel for the Kefauver committee and Roy Cohn and David Schine still do it for the McCarthy committee. As far as we know, however, Fitzgerald is the first committee counsel to issue a report knowing that it is contrary to the chairman's wishes.

"Borrowing a leaf from Pearson's book, we predict that Fitzgerald will be fired."

Deadline Nearing on Reservations For A. M. A. Session

Those who plan to attend the Clinical Meeting of the American Medical Association in St. Louis, December 1-4, are reminded to make their hotel reservations as soon as possible.

Hotel reservation blanks are appearing in current issues of *The Journal of the A.M.A.* The blank should be filled out, indicating choices of hotels and mailed to: Chairman, American Medical Association, Subcommittee on Hotels, Hotel Reservation Bureau, Room 406, 911 Locust St., St. Louis 1, Mo. Deadline for making reservations through the housing bureau is November 1.

An excellent program is in store for physicians. Main subjects on the program are neurology and psychiatry, arthritis, dermatology, gastrointestinal diseases, pediatrics, obstetrics and gynecology, pulmonary diseases, orthopedics and surgery.

Many other features are in store, including business meetings of the House of Delegates.

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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NEWS STORY ON HOSPITAL BILLING WAS ERRONEOUS

Ohio physicians were confused, perhaps startled, to say the least when they read several weeks ago in the newspapers, a United Press story about the American Hospital Association session in San Francisco.

The United Press story, released on the opening day of the meeting said that the American Hospital Association had adopted a resolution advocating the lumping of all hospital expenses so patients would only have to pay one bill.

"In other words," the story said, "patients will no longer have to pay a separate amount to the doctor, anesthetist and hospital."

This story, giving the writer's interpretation of the Joint Hospital-Physician Relationship report of the hospital association trustees and trustees of the American Medical Association was erroneous and misleading in every way.

Several conferences were held with United Press officials, but the press association steadfastly refused to carry a corrective story on its wires, according to American Hospital Association people.

An official statement was prepared giving the actual facts. It was signed jointly by Dr. Edwin L. Crosby, president of the American Hospital Association, and Dr. Edward J. McCormick, president of the American Medical Association. One important paragraph of the statement said:

"This (United Press) interpretation of the report on hospital-physician relationships by the Joint Committee of the Boards of Trustees of the American Medical Association and the American Hospital Association would, if allowed to stand uncorrected, largely nullify the intent of the resolution. This resolution was not designed to alter billing practices. It was designed to establish mutual understanding between physicians and hospitals."

When many newspapers published the original United Press story and not the follow-up corrective story, the net result was confusion in its broadest sense.

PROGRAM SUGGESTION FOR COUNTY SOCIETIES

Last year we suggested that each County Medical Society devote at least one meeting to a discussion of Workmen's Compensation problems and procedures and have a speaker from the staff of the Ohio Industrial Commission. In addition, it was recommended that physicians have their office secretary or clerk attend the meeting in order to secure valuable information on paper work and a better understanding of the Commission's procedures.

Quite a number of County Medical Societies did this and were pleased with the results. Well-informed members of the Commission's staff covered those meetings. Many problems which had been causing confusion were discussed and clarified. Suggestions were made regarding proper procedure in preparing and submitting fee bills and claim forms. Some worthwhile ideas were given to the Commission representatives on how procedures might be changed to make them more practical.

How about your County Medical Society? Has it had such a meeting? If not, why don't you suggest to your society officers or program committee that such a meeting be arranged.

Societies which may be interested should write Mr. Clark C. Grubbs, assistant supervisor, Claims Section, Ohio Industrial Commission, 309 State Office Building, Columbus 15, for information and for available dates.

This is one subject just about every physician bumps up against at some time during the course of a year—many times in some instances. Problems can be eliminated and time saved if routine procedures are handled correctly. It is the function of a County Medical Society to give its members and their office aides an opportunity to get accurate information and good advice on such matters.

GOVERNOR'S OPINION IS SOUND AND TIMELY

Not long ago, a controversy developed between Dr. John D. Porterfield, Ohio director of health, and an Ohio Congressman over whether or not the Ohio Department of Health had sufficient funds to finance a certain maternal and child health project. Porterfield stated that the department did not have enough money to take on the project, inasmuch as the State of Ohio appropriates nothing for maternal and child health activities; funds now being used are Federal funds; and all Federal money for that purpose is now earmarked for other programs. The Congressman insisted money was available; that Porterfield mis-stated the facts; and should be discharged.

The Congressman is a good fellow. But, he just wasn't familiar with the rather peculiar way in which Ohio has been financing a large part of its public health activities. Despite protests from

New Horizons in Antibiotic Therapy

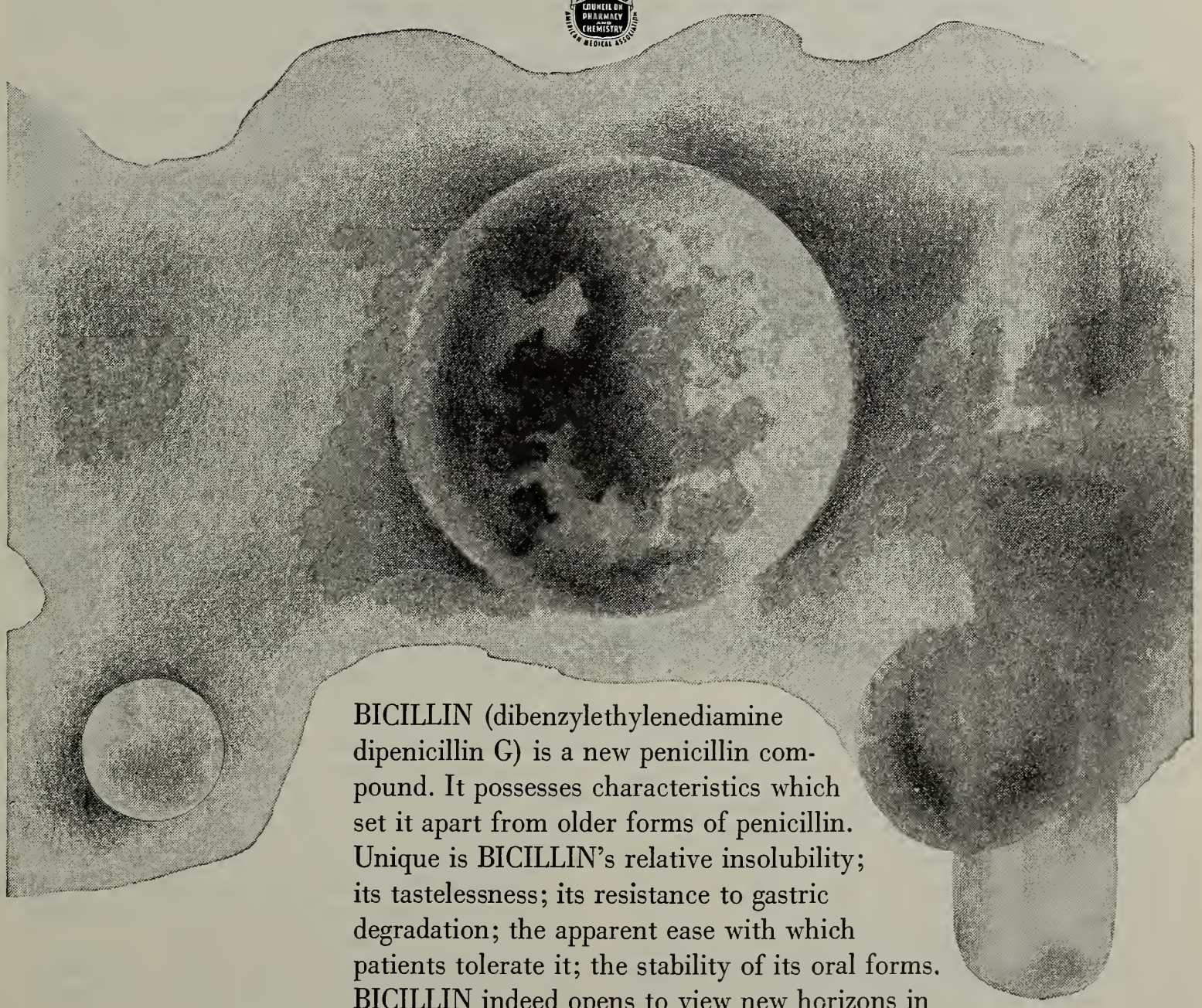
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Dr. Porterfield, and others, Ohio for too many years has been taking handouts from Washington to finance work which the State of Ohio should have financed. Obviously, this is a bad practice but others, not Porterfield, should be saddled with the blame.

Be that as it may, the most significant thing about the hassle, which was based on a misunderstanding, is the public statement issued by Governor Lausche regarding the suggestion that Porterfield be relieved of his post, to wit:

"Dr. Porterfield is undoubtedly one of the ablest public health directors of the United States. He was appointed by Gov. Thomas J. Herbert. I do not know his politics. For four and a half years I have watched his fearless, efficient and faithful service to the public.

"I am sure that in the letter which he wrote he expressed himself in accordance with the facts as he understood them. Dr. Porterfield will remain in my cabinet."

In our opinion, the Governor's statement correctly states the case. Ohio will just be plain lucky—probably more lucky than it deserves—if it is able to keep Porterfield in his present post. Sources elsewhere have had their eyes on him for some time. It is no secret that he has received some flattering offers to leave Ohio. If he does so, the State of Ohio will find that the job of securing a man who can adequately fill his shoes will not be an easy one.

SOME IMPORTANT "DON'TS" REGARDING NARCOTICS

The "narcotics problem" is one which is receiving increasing attention by civic groups and law enforcement agencies. For that reason it behooves every physician to watch his P's and Q's in how he handles this part of his practice. Warnings and sound advice on this question can not be publicized too often.

Here are some suggestions—some "don'ts"—which should be observed by the physician for the protection of the public as well as himself:

Don't leave prescription pads around.—Addicts want them for effecting narcotic forgeries.

Don't write a narcotic prescription in lead pencil.—Avoid writing any Rx in pencil, many are changed to call for morphine.

Don't write for narcotics in this way: Morphine HT ½ ‡ X *or* Morphine HT ¼ ‡ 10. Several X's or zeros can be added to raise the amount. Use brackets or spelling.

Don't carry a large supply of narcotics in your bag.—Addicts are on the lookout for these in doctor's offices and cars.

Don't store your office supply where patients can get at it.—Avoid storage near sink or urinal. The patient may ask to use these.

Don't fall for a good story from a stranger claiming ailment that usually requires morphine.—The addict can produce bloody sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

Don't give a narcotic Rx to another without seeing the patient.—Addicts have posed as nurses to get doctors to prescribe narcotics.

Don't write for large quantities of narcotics unless unavoidable.—Diversion to addicts is a profitable business, as much as $1 for ¼ grain M.S.

Don't prescribe narcotics on the story that another M.D. had been doing it.—Consult that physician or the hospital records whenever possible.

Don't leave Rxs signed in blank at the office for nurses to fill in.—Signed blanks are bad practice and many have been stolen by addicts.

Don't treat an ambulatory case of addiction. Addicts must be under proper control.—Addicts go to several M.D.'s at a time. Notify the narcotics officials.

Don't dispense any narcotic without keeping a record of it.—Bedside and office administration are permitted without record.

Don't buy your office narcotic needs on Rx blanks in name of a patient.—The law requires you to use an official order form.

Don't resent a pharmacist's call for information about an Rx you may have written.—The pharmacist is held responsible for filling forgeries. Please co-operate.

A narcotic prescription is not properly executed unless it bears the date of issue, the name, address and registry number of the prescriber, the name and address of the patient, directions for use, the signature of the prescriber in ink or indelible pencil. The date may neither be changed nor corrected except by the prescriber.

Telephone prescribing of narcotics is held by narcotics enforcement officials as illegal.

DOCTORS PSYCHOANALYZED BY THEIR AIDES

Cleveland physicians did a smart thing when they asked their office assistants to tell them what is right and what is wrong with their office procedures and patient relationships. Nothing like getting the low-down from those who are in a position to give first-hand criticism! Here's how Don Dunham, medical writer for the *Cleveland News*, described the experiment:

"Just pull up a chair, doctor, and be comfortable. The women who work for you in your offices want to take your pulse, maybe even do a little psychoanalyzing.

"In effect, this happened recently when the secretaries, receptionists and nurses or technical assistants attended a public relations conference sponsored by the Cleveland Academy of Medicine. Lengthy questionnaires were distributed to the 326 women and 214 filled them out.

"This is what the unsigned questionnaires (so

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they could let their hair down) reveal about their bosses, the doctors:

"Their biggest problem is arranging appointments and then trying to pacify patients when the physician is absent, late, or too busy to get all his work done.

"Insurance forms are the biggest personal bugaboo, ranking well ahead of collecting fees. The office women want more information on techniques in both fields.

"Their chief desires are a raise (ah, there, doctor), that their boss would better evaluate his time with patients, explain to the office aide what is expected of her and report his house and hospital calls to her.

"Biggest general problems are lack of time, scheduling appointments, phone conversations, inconsiderateness of the public and the demands of patients.

"But you doctors came out right well with the women who—next to your wives—probably know you best.

"Your relations with your patients are excellent, said 153; good, said 37 more and just fair according to 13. Only one said they were poor. About 13 per cent suggested promptness might improve those relationships.

"Chief complaint from patients, naturally enough, is about fees. But a large number again cited waiting for appointments and a few complained of difficulty in obtaining appointments.

"The patients need an explanation of fees, an explanation of their illness, and an explanation of what goes on behind the scenes in hospitals, these workers say. Your weakest point is in explaining things to patients, they said.

"They respect you for your complete attention to the individual, for your honesty, your ability to create confidence, and for your understanding, sympathy and sincerity."

NEVER HURTS TO ADMIT A MISTAKE—TRY TO CORRECT IT

Confession is good for the soul! Apparently that's what Dr. S. S. Hall, president of the West Virginia State Medical Society thinks. Following is an excerpt from his President's Page in the *West Virginia Medical Journal*:

"I personally helped to have the Veterans Hospital located in Clarksburg in that I contributed some money for the purchase of land as well as some time in an effort to have Clarksburg selected as the site for the new hospital. I was just trying to be a good, loyal citizen. It was a mistake. These hospitals should have been located as originally planned near to and as a part of teaching centers and institutions."

Dr. Hall's confession that he was wrong points up what can happen when civic-minded individuals and politicians let their actions be guided by emotion rather than common sense.

Do You Know? . . .

Dr. Richard L. Meiling, Columbus, associate dean of the Ohio State University College of Medicine, was elected commander of the medical division of the Air Force Association during its recent convention in Washington, D. C. Dr. Meiling holds the rank of brigadier general in the Air Force Reserve. He is Treasurer of the Ohio State Medical Association.

* * *

Dr. W. James Gardner, head of the Department of Neurosurgery, Cleveland Clinic, left in early September for Lisbon, Portugal, where he was scheduled to appear on the program of the Fifth International Congress of Neurology. He also was scheduled to deliver lectures before medical groups in Copenhagen and Stockholm.

* * *

Dr. Joseph T. Wearn, dean of the Western Reserve University School of Medicine, is the new president of the Association of American Physicians.

* * *

Dr. Walter A. Reiling, Dayton, was honored at a dinner attended by approximately 200 Optimists and guests from 13 other Dayton service clubs. He was installed as president of Optimist International in June.

* * *

Recently named officers of the Western Reserve University Medical Alumni Association are Dr. Webb F. Chamberlain, Jr., president; Dr. R. J. Foster, New Philadelphia, first vice-president; Dr. Donald D. Brannan, second vice-president; and Dr. William L. Schlesinger, secretary-treasurer. All except Dr. Foster are of Cleveland.

* * *

Dr. Ewing H. Crawfis, who resigned as superintendent of the Cleveland State Hospital in 1951, has been named director of the California Department of Mental Hygiene. He succeeds Dr. Frank F. Tallman, former Ohio mental hygiene commissioner, who resigned to accept a professorship at the University of Southern California.

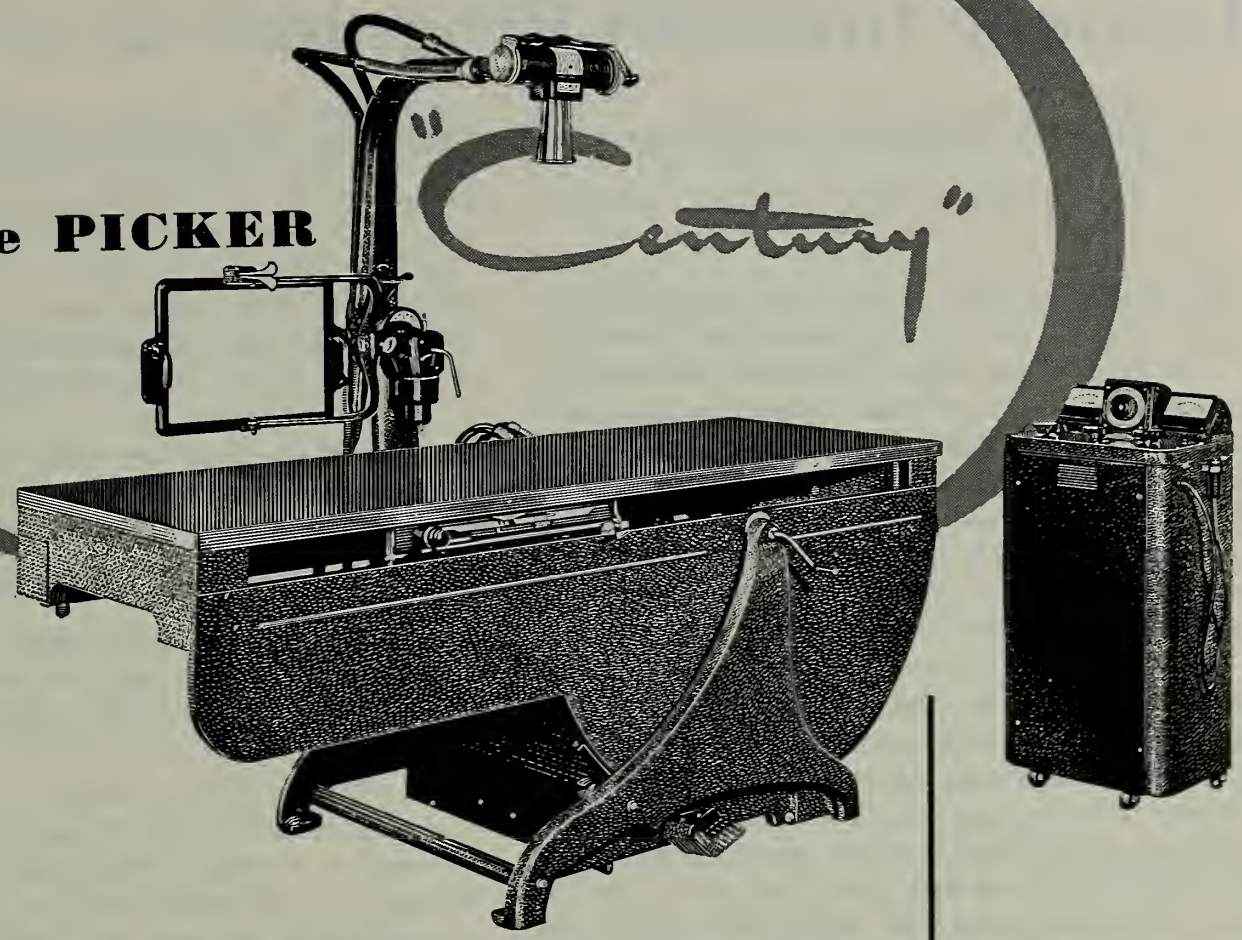
* * *

Dr. Charles W. Asbury, graduate of the University of Cincinnati College of Medicine and a former fellow in the Department of Preventive Medicine and Industrial Health of the University, has been named medical officer for the central region of the Pennsylvania Railroad with headquarters in Pittsburgh.

* * *

Ohio University, Athens, proudly claims as one of its alumni the oldest living college graduate in the Nation. He is Dr. Philip Zenner, of Cincinnati, who graduated from the institution in 1870 and celebrated his 101st birthday on last May 17.

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Immune Globulin Program . . .

Health Department Relaxes Somewhat the Restricted Use of Globulin To Include More Polio Contacts; Discrete Use of Supply Is Requested

IN a memorandum issued to local health commissioners, Dr. John D. Porterfield, director of the State Department of Health, announced a somewhat modified distribution of immune globulin for the prevention of paralytic poliomyelitis, based on experience during the first three months of the program's operation.

The supply is available now for "intimate extra household contacts" as well as to household contacts of a diagnosed case.

Dr. Porterfield stressed the importance of physicians using a reasonable amount of discretion in designating extra contacts eligible for immunization, and warned that an indiscriminate demand on the supply might force the Department to go back to the more restricted program. It is only by a careful allocation of the supply that the Department can extend its use to the next higher priority of contacts, Dr. Porterfield emphasized.

The memorandum from Dr. Porterfield reads as follows:

PROPOSED CHANGE IN METHOD

The Executive Order of May 11, 1953, restricted the use of immune globulin for the prevention of paralytic poliomyelitis to the household contacts of a diagnosed case. At the time the Order was written it was estimated that it would require approximately 60 cc. of immune globulin to inoculate the eligible household contacts of each case. Experience during the last three months has shown that in practice the amount required for each case has been closer to 30 cc. Up to the present time, therefore, approximately 36,000 cc's of our initial allocation of 88,000 cc's should have been utilized.

Because of these facts and because we have been notified by the national allocating authority that Ohio is eligible for a 46,000 cc supplementary supply, we have decided to attempt to broaden the usage of immune globulin to intimate extra household contacts as well as the household contacts of a diagnosed case.

We fully realize the great difficulties which will be faced by the local health commissioners when forced to make the decision as to which of the many extra household contacts are eligible. We do not feel, however, that rigid definitions can be given and the responsibility of decision must be that of the local health commissioner. It is strongly suggested, that every attempt be made to keep the amount utilized close to a 60 cc average with an absolute upper limit of 100 cc. If this can be done we estimate that we will have an adequate amount of globulin to last the rest of the season, and will not be in the unfortunate position of having unused material left over at the end of the year. It is also hoped that more paralytic poliomyelitis might be prevented by this system.

RECOMMENDED CRITERIA

Although the definitive decision as to what criteria will be used will be that of the health commissioner the following suggestions are recommended:

1. Eligible extra household contacts should be limited to children 10 years and under and pregnant women. Depending upon the age range of the poliomyelitis cases that have occurred this year in your health jurisdiction the maximum age may be increased to 15 years but it is recommended that individuals over this age not be included.

2. Intimate contacts should include only those who have had close contact with the patient within a period of 7 days prior to the onset of the diagnosed case. An example of such contact would be the children living next door to a diagnosed case who had been constant daily playmates. Another would be friends or relatives who visited the home of the case for at least several hours during the incubation period. It is strongly recommended that school room contacts **not** be considered eligible unless they fall into one or the other of the two categories above. The inoculation of school room contacts would very rapidly deplete our supply. It should be pointed out in this regard that secondary cases in a school room are unusual.

This change in the allocation method has been suggested after a very careful consideration of the situation. It is conceivable that it will be impossible to proceed with this system for the rest of the year and if this becomes clear we will have to revert to the household contact method.

Your cooperation with this change is urgently requested.

Dr. Merrill F. Steele, superintendent of Christ Hospital, Cincinnati, was installed as president of the American College of Hospital Administrators at its recent meeting in San Francisco.

Tuscarawas School Health Day . . .

Excellent Turnout, Including School Administrators and Teachers, Responds as County Medical Society Sponsors Cooperative Program

An estimated 600 city and county school administrators, teachers, physicians and public health personnel attended the Tuscarawas County School health day, sponsored by the Tuscarawas County Medical Society September 11 in New Philadelphia.

This was the second conference of this type sponsored by the Society, the first one being held in June, 1950, in the same city.

Excellent cooperation was received from the city and county school superintendents who dismissed classes throughout the county so that teachers could attend the afternoon and evening sessions of the conference.

The program opened with an address of welcome from Dr. Benjamin Pilloff, New Philadelphia, president of the society.

PANEL DISCUSSION

There followed a panel discussion on the subject, "The Physician and School Health," moderated by Dr. Elizabeth Rowland-Aplin, Gnadenhutten, secretary of the Society. The following topics were introduced for five minute periods prior to the opening of the discussion:

"An Adequate School Dental Health Program," by a member of the Tuscarawas County Dental Society.

"The Physician's Appraisal of a Student's Health," Dr. R. E. Rinderknecht, Dover.

"The Prevention and Control of Communicable Diseases," Dr. R. B. Giles, New Philadelphia.

"Health Safeguards in Physical Education," Dr. V. C. Nipple, Midvale.

"Mental Health in the Classroom," Dr. G. D. Woodward, Dover.

"Health and Medical Supervision of School Personnel," Dr. C. M. Fisher, Dover.

"The Physician's Role in Health Instruction," Dr. R. L. Oyer, Sugarcreek.

"Preparing for School Emergencies of Sickness and Accident," Dr. C. M. Dougherty, New Philadelphia.

OTHER FEATURES

After the panel discussion Mr. Paul Schuster, consultant in public health education for the Ohio Department of Health, showed a movie entitled "School Health in Action," which was produced in Oklahoma by the Oklahoma State Departments of Health and Education and the State Medical and Dental Societies.

Dr. R. D. Hildebrand, the county health commissioner then spoke on "School Health Services of the Tuscarawas County General Health District."

"Standards for Safety and Sanitation for Schools" was the topic assigned to Messrs. Norman and Robert Miller, sanitarians for the county health department. Mrs. Ethyl Patterson, nutri-

Educators and Physicians Get Together on School Health



When Tuscarawas County physicians invited those interested in school health to get together for a program, some 600 persons responded and about 200 remained for dinner and the evening program as shown above—an excellent response in both instances.

tion consultant for the Ohio Department of Health, discussed "Standards for School Food Services." Mr. Paul Mico, health educator for Tuscarawas County, talked on "Textbooks on Health."

Approximately 200 people attended a dinner that evening to hear Dr. Charles F. Good, Cleveland, a member of the Committee on School Health of the Ohio State Medical Association, present an address on "Building an Adequate School Health Program." He was introduced by Dr. R. J. Foster, New Philadelphia, Seventh District Councilor for the Ohio State Medical Association.

The meeting was also attended by Mr. Hart F. Page, Columbus, secretary to the Committee on School Health of the Ohio State Medical Association. Mr. Page presented one of a number of school health exhibits which were features of the meeting.

The committee in charge of the meeting included Dr. Oyer, chairman; Dr. Aplin and Dr. W. E. Hudson, New Philadelphia. They were assisted by the Woman's Auxiliary to the Tuscarawas County Medical Society.

Buckeye News Notes . . .

Bowling Green—A campaign has been launched to enlarge the 50-bed Wood County Hospital opened in August, 1951. Staff members announced that demands were running 20 to 40 per cent above the capacity of the hospital.

Cleveland—Dr. David R. Weir, associate professor of medicine at Western Reserve University School of Medicine, has been named chief of medicine and director of medical services at Highland View, Cuyahoga County's new hospital for the care of the chronically ill.

Columbus—Grant Hospital is planning an expansion program, first stage of which is to take over an adjacent 24-room building. Eventual plans call for erection of a new $800,000 addition.

Columbus—An appraisal of the public health program and facilities in Columbus and Franklin County is now underway by a 100-member citizens' committee, under sponsorship of the Metropolitan Health Council.

Columbus—St. Ann's Hospital recently opened a new Family Clinic, services of which will include premarital instruction and guidance, marital and family counseling and guidance on moral problems arising in married life.

Marion—Dr. Neuman Sifritt was honored at a dinner and reception upon his resignation as Marion County health commissioner, a post he held since it was created in 1920.

Marion—Dr. Frederick T. Merchant spoke on the subject, "The Doctor and the Community," at a meeting of the Marion Kiwanis Club.

Medical Civil Defense Program Planned As "Target Areas" Are Announced

Two events of utmost importance to physicians interested in the civil defense program for Ohio have been announced. One is the release of names of 21 strategic target areas in Ohio in event of enemy attack, and the other is announcement of a medical civil defense conference to be held in Cincinnati.

The 21 target areas are centered in the following cities:

Cleveland	Canton	Lima
Cincinnati	Steubenville	Lancaster
Columbus	Hamilton	Zanesville
Toledo	Middletown	Bellaire
Dayton	Springfield	Mansfield
Youngstown	Ironton	Lorain
Akron	Portsmouth	Elyria

The fourth national Target Areas Medical Civil Defense Conference will be held at the Netherland Plaza Hotel, Cincinnati, November 14-15.

Medical administrators in civil defense from major cities of the nation will exchange opinions and mutual experience.

Health and special weapons defense division of the Federal Civil Defense Administration will discuss its plans and policies for 1954. The American Red Cross will outline the problems of casualty care encountered during tornadoes of early summer. The American Medical Association will define the role of the individual physician and the County Medical Society in civil defense.

Invitations to the conference have been extended primarily to one representative each, from County Medical Societies and Health Divisions in city civil defense organizations. Other persons interested in civil defense are invited to attend in a non-official capacity.

Additional information may be obtained from: Harry P. Mendelsohn, M. D., Conference Chairman, 4534 Whetsel Ave., Cincinnati 27.

Braceland Replaces Sargent on Selective Service Advisory Committee

The National Advisory Committee to the Selective Service System has accepted with regret the resignation of Dr. James C. Sargent, of Milwaukee, who has served on the committee for years.

To replace him, the President has appointed Dr. Francis J. Braceland, at present psychiatrist-in-chief at the Institute of Living, Hartford, Conn. During World War II, he was chief of neuropsychiatric service with the Navy and subsequently served with the Mayo Clinic in the same capacity.

Statistics and Social Welfare . . .

Incomplete or Carefully Selected Data Have Been Used Too Often To Justify Need for Certain Welfare Programs, C. of C. Economist Says

IN A RECENT ISSUE of *American Economic Security*, publication of the Chamber of Commerce of the United States, W. Glenn Campbell, research economist for that organization, described how statistics have been shuffled around for too many years in efforts to substantiate the need for certain social welfare reforms.

Since the new national administration has launched a thorough study of the entire Social Security Program, Mr. Campbell's comments are significantly timely. His article on the subject follows:

* * *

The new Administration is now beginning the task of formulating and implementing its program of social legislation. In order that it may devise the best possible program, it is important to single out the areas where selected statistics have been presented in support of proposed social welfare programs in the past.

No one disputes the need for economic statistics. Without comprehensive statistics it is virtually impossible to formulate wise economic and social policy. Unfortunately, however, programs are too often formulated and sold on the basis of incomplete or carefully selected statistics.

DISTRIBUTION OF INCOME

Perhaps the area where misleading statistics have been most frequently quoted is in the field of the distribution of income. For example, the recent Magnuson Report on the Health Needs of the Nation stated that "about half of our families receive $3000 or less in annual income." Then it used this statement as evidence of the need for government aid for medical care.

Literally interpreted, of course, the statement is true. Of the total families and unrelated individuals in the United States, 50.1 per cent did receive less than $3,000 in *money* income in 1950. But when the statement is analyzed more carefully it becomes meaningless. There is a heavy concentration of single individuals and small families in the less than $3,000 income group; 84.3 per cent of the individuals not in families received money incomes of less than $3,000 in 1950, whereas 42.5 per cent of multiple person families were in this category.

Breaking the multiple person families down by size of family, we find the following percentages with incomes under $3,000 in 1950:

2 person families 53.5 per cent
3 person families 39.6 per cent
4 person families 33.4 per cent
5 person families 34.7 per cent
6 person families 39.4 per cent

This shows that a large percentage of the families who receive less than $3,000 in annual money income can afford the cost of medical care.

When multiple-person families are examined on an urban-rural breakdown, we also obtain significant results. Of all urban families, 34.2 per cent receive less than $3,000 a year in 1950 whereas 69.7 per cent of rural farm families fell in this category. However, before we conclude that most farm families are in want, income in kind and under-reporting of income must be taken into account.

The Bureau of Agricultural Economics has calculated that, when food is valued at retail prices, the average value of nonmoney income per farm family amounted to $1,100 in 1948. In addition, there is evidence that the incomes of farm families are under-reported to a greater extent than those of nonfarm families.

CAUSES OF INCOME INEQUALITY

A popular view of income inequality is that it is all caused by inequality in the ownership of property. There is no question of the fact that property ownership is quite unequally distributed—more so than income. But this is not the place to argue the pros and cons of private property, and the role that private property and individual initiative and accumulation have played in the growth of the American productive machine.

The fact of the matter is that even if all property were socialized, income inequality would still largely remain. Most of the inequality in the distribution of income results from differences in the level of wages and salaries. Income from property is a relatively small percentage of total income. If all the income from rent, dividends and interest payments had been divided equally amongst all the spending units in the country, they would have received only about $562 per unit in 1951. But if all compensation from wages and salaries had been divided equally

in 1951, each spending unit would have received about $3,440.

An interesting fact about income from property is that the two income groups who receive the largest percentage of total income from property are the highest and the lowest groups. All the income groups in between obtain a relatively small percentage of their income from property. Practically all the income of these groups is from labor services.

An important reason why property incomes are relatively more important at the lower end of the income scale is that there are so many retired persons in this group who are living off annuities and the proceeds of whatever savings they have accumulated over a lifetime of work.

AN ECONOMIC AND SOCIAL REVOLUTION

There has been a substantial trend towards more equality in the distribution of income in recent years. Dr. G. H. Moore of the National Bureau of Economic Research has estimated that the upper 1 per cent income group received 16 per cent of the nation's income in 1913 but only 9 per cent in 1948. Dr. Moore reports that progressive taxation accounted directly for only about one-fourth or one-fifth of the decline in income inequality.

The major explanation is to be found in a drop in the main source of income for the upper income group—dividends, interest payments and rent (property incomes). For example, in 1929 property incomes totaled 22.5 per cent of total personal income but in 1951 the corresponding percentage was only 11.5 per cent.

This clearly shows how questionable is the validity of the claims continuously made by trade unions that profits are increasing unduly and that workers are not getting a fair share of total income. This attempt to foment class strife in America is entirely without foundation in fact.

THE WELFARE STATE

One of the hardiest perennials is the myth that a major virtue of large and comprehensive welfare outlays is that they will redistribute income on a large scale from rich to poor. This thesis has been tested in several European states and it has been found that the poor pay more in taxes than they receive in benefits even though the tax system is steeply progressive.

Rates of the U. S. federal personal income tax vary from 22.2 per cent to 92 per cent. Statistics show that not much more could be squeezed from high income people. In spite of the fact that taxes are so heavy on the high income groups, there is no question of the fact that the low income groups also bear a heavy burden of taxation. Figures compiled by the Tax Foundation show that a $3,500-a-year income family in the United States paid a total of $1,097 or 31.3 per cent of its income in taxes, both direct and hidden, to all levels of government in 1952.

The heavy burden of government expenditures has meant that all income groups have, of necessity, had to pay heavy taxes. This is the major reason why, although productivity has increased substantially in recent years, the increases in the standard of living of all groups, including the low income group, have been so disappointing.

Only to the extent that the new Administration is able to correct the foreign and domestic policy errors of the past few years will there be a chance for an appreciable immediate increase in the standard of well-being of the low income groups. This could come about through reduction in the taxes which they currently pay.

WHO ARE THE LOW INCOME PEOPLE?

The view is widely held that the low income groups consist of families who have existed more or less permanently in a depressed state. It is true that the money income of a large percentage of farmers is so small that they seldom find themselves in any other than the low income group. But in this case nonmoney income and under-reporting must be taken into account.

During the postwar period most of the nonagricultural low income families fell into the following categories—families headed by persons over 65 years of age, families headed by women because of widowhood, desertion or divorce, and families headed by disabled persons.

During periods of large scale unemployment families headed by unemployed persons would constitute another major group.

The vast majority of families headed by regularly employed persons fall into the category commonly known as the "great American middle class." This is the reason why wage increases so seldom really help the low income groups. In fact, history shows that excessive wage increases which cause inflation are positively harmful to the well-being of the poor. There is no doubt that the inflation of the past decade has worked serious hardships on the low income groups.

TOWARD REAL SOCIAL WELFARE

The proper approach to the problem of social welfare is to induce every person *himself* to see the importance of providing *both* by private and by public means for the time when he may find himself in the low income family category. We have already seen that the turnover in the low income group is high. Most of us find ourselves in one of the low income categories some time during our life. At the very least we all expect to grow old.

Unbiased statistics will show what was wrong with the Fair Deal approach to social welfare. Basically, this approach attempted to force everyone to enjoy the benefits of the welfare state instead of aiding the special groups in the popula-

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Literature on request

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tion for which public action is needed. This is both unnecessary and impossible to achieve as the European welfare state experiments have shown.

It is, however, economically possible to protect these special groups and at the same time not destroy economic change and growth, which is the basis of real economic security. This is the challenge which faces the new Eisenhower Administration in the field of social welfare.

Farm Accidents Caused by Individual Carelessness

One of the most hazardous of all occupations today is farming. Most farm accidents are preventable, and usually only one person is to blame—the person involved in the accident—it was stated editorially in a recent issue of *The Journal of the American Medical Association.*

In 1952, 62 out of every 100,000 farm residents lost their lives as a result of some sort of farm accident, the editorial pointed out. An additional 1,200,000 farm residents suffered injuries.

Farming has the third highest death rate among the major industries in the nation, surpassed only by the mining and other extractive and construction industries, according to the editorial.

Motor vehicle accidents among farm residents accounted for 6,000 deaths and 210,000 injuries, home accidents for 3,500 deaths and 540,000 injuries, occupational accidents for 3,800 deaths and 320,000 injuries, and public non-motor-vehicle accidents such as streetcar or sidewalk mishaps for 1,300 deaths and 150,000 injuries.

"Increasing use of machinery on farms may be a causative factor in the high death rate," the editorial stated. "There were about 700 fatal and about 25,000 nonfatal accidents involving farm wheel tractors in 1952.

"Farming is one of the few occupations in which children are permitted to be close to operating machinery. One case in ten involved a child under five years of age. Deaths among the very young often resulted from falls that occurred while the children were riding on tractors.

"One-third of the tractor fatalities in Minnesota and Iowa during 1949-51 occurred in highway accidents. Considering the small proportion of time that tractors are on the highways, the accident rate during this use is probably much higher than the rate during use on the farm.

"On the basis of corn harvest accidents in Iowa during 1952, it has been estimated that doctor and hospital costs per accident average $160, while the time lost averaged 30 days."

Dr. Howard Dittrick, director of the Howard Dittrick Museum of Historical Medicine, Cleveland, gave the opening television lecture on an exhibition of the story of medicine in art in Milwaukee on September 11.

Toledo Chosen To Receive Special Series of Color TV Programs On Cancer

Toledo has been chosen as one of a few cities in the nation to receive an experimental series of cancer clinic television broadcasts to acquaint the medical profession with up-to-the-minute methods of detecting, diagnosing and treating cancer.

The American Cancer Society, in cooperation with the Columbia Broadcasting System, is sponsoring the series of 30 weekly one-hour color broadcasts beginning October 21.

In Toledo, the programs will be received at the headquarters building of the Academy of Medicine of Toledo, 3101 Collingwood Avenue. The time has been announced as 5:00 to 6:00 p. m. Other cities to receive the programs are New York, Boston, Philadelphia, Pittsburgh and Detroit. Additional cities may be added after initial trials.

Four-by-six feet screens will be used to accommodate as many as 500 viewers to a screen. Programs will originate in specially constructed studios in New York's Memorial Cancer Center and the Francis Delafield Hospital to the Columbia Presbyterian Medical Center.

Dr. Charles S. Cameron, medical and scientific director of the American Cancer Society, declared that the television series is aimed at reducing the number of lives lost because of delayed diagnosis.

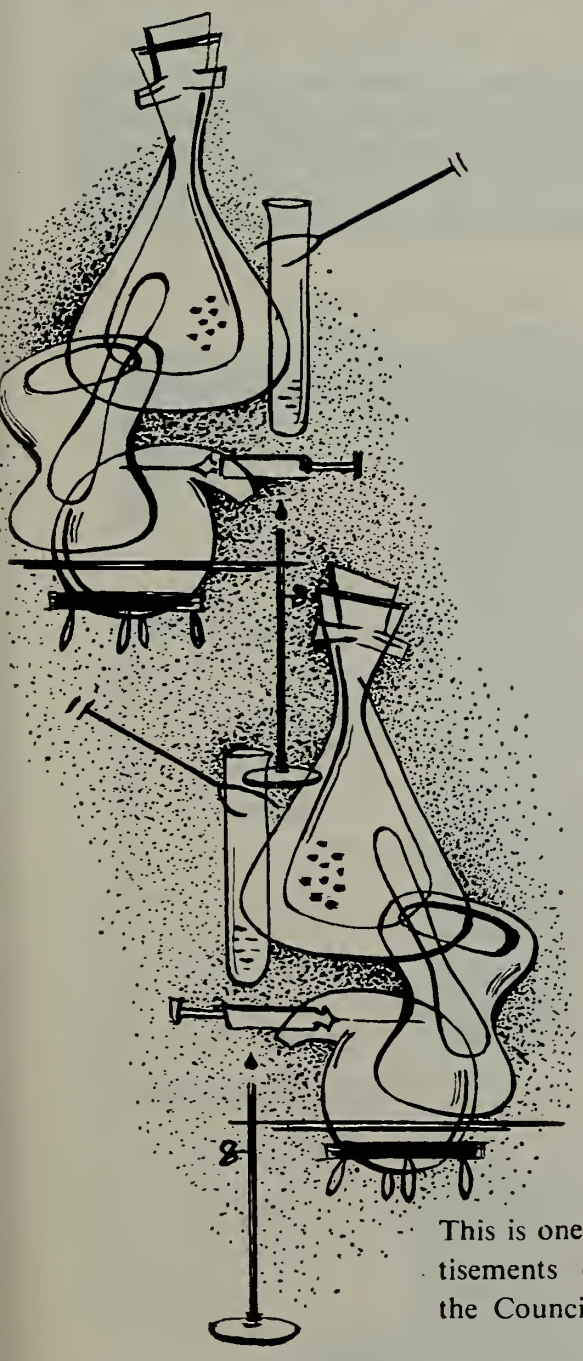
The telecasts will consist of both "live" action and specially prepared films. Kinescopes will be made of each live telecast and will be available for later showing.

Many of the nation's outstanding doctors and scientists have participated in planning the series. The product represents their ideas of information which will be most effective in reducing the present enormous and rising cancer mortality.

The TV Program Advisory Committee for the Toledo broadcast consists of the following persons: Academy of Medicine of Toledo—Dr. Edward Burns, chairman, and Dr. Willis Peck; American Cancer Society—Dr. William Meffley and Dr. Elmer Paul; Maumee Valley Medical Advancement Trust—Dr. W. Wendell Green and Dr. A. A. Applebaum; City Health Department—Dr. Walter Hartung; Academy of General Practice—Dr. Charles R. Forrester; Dr. Thomas E. Rardin, Columbus, and Dr. George Lemmon, Perrysburg, outgoing and incoming presidents of the Academy, respectively; Cancer Control Committee of the Ohio State Medical Association—Dr. C. E. Hufford.

All physicians in good standing with their respective County Medical Societies, especially those in northwestern counties of Ohio, are invited to attend the broadcasts.

What is the status of____?



Many times you have asked yourself, "Is the indicated drug Penicillin . . . Chloramphenicol . . . Aureomycin . . . Sulfadiazine . . . a combination . . . or what?"
This same problem may confront you many times . . . not only with the antibiotics—but actually in any specific field where there are numerous drugs . . . and you are faced with the problem of determining which might be the therapy of choice for a given condition.

The need for such clarification has always been apparent to the Council on Pharmacy and Chemistry of the American Medical Association. Its frequent publication of special status reports in THE JOURNAL is designed to help answer such questions for you.

Information about new drugs—clinically proved indications . . . experimental uses . . . correct dosages . . . contra-indications . . . and similar facts—is frequently presented by the Council. Its announcements of newly accepted products also help keep you up-to-date on new and useful drugs. These notices which appear in THE JOURNAL almost every week can be a definite guide to you in knowing what preparations are Council accepted . . . how they are best used . . . and how they can be most effective in your daily practice.

Insistence on Council accepted products is one reliable guide to clinically tested products.

This is one of a series of advertisements designed to explain the Councils' functions to you.

Rural Health Activities of O. S. M. A. Explained to Trade Executives

Activities of the Ohio State Medical Association in the field of rural health were explained by Hart F. Page, Secretary of the Committee on Rural Health, at the Seventeenth Annual Conference of Executives of State and Local Trade Associations held at Granville, September 16 and 17. The conference was sponsored by The College of Commerce and Administration of Ohio State University in cooperation with the Ohio Trade Association Executives, of which George H. Saville, Director of Public Relations, Ohio State Medical Association, is president. Mr. Page gave one of five case reports illustrating public relations in action.

Dr. McCormick To Speak at National Conference on Crippled Children

Dr. Edward J. McCormick, Toledo, President of the American Medical Association, heads a list of authorities scheduled to speak on the care, treatment and training of crippled children at the 1953 annual convention of the National Society for Crippled Children and Adults, November 12-14 at the Palmer House, Chicago.

Additional information on the program may be obtained from the National Society, 11 So. LaSalle St., Chicago 3, or from the Ohio Society for Crippled Children, 5 W. Broad St., Columbus.

Ohio Academy of General Practice Announces Election of Officers

Dr. Herbert W. Salter, Cleveland, was named president-elect of the Ohio Academy of General Practice, at its annual meeting in Cleveland, September 15-17. He will assume office as president at the annual meeting next year.

Dr. George H. Lemon, Perrysburg, was installed as president for the current year, to succeed Dr. Thomas E. Rardin, Columbus. Dr. Earl D. McCallister, Columbus, was reelected for his fifth term as secretary-treasurer.

The following District directors were elected: District No. 1, Dr. Joseph Lindner, Cincinnati (reelected); District No. 3, Dr. James R. Jarvis, Van Wert (reelected); District No. 5, Dr. Jay B. Price, Cleveland; District No. 7, Lewis L. Liggett, St. Clairsville; District No. 9, Dr. H. D. Chamberlain, McArthur (reelected); District No. 11, Dr. Henry W. Lehrer, Sandusky (reelected).

Dr. Earl C. Van Horn, Cincinnati, was elected delegate (1953-1955) to the American Academy of General Practice, and Dr. Ralph L. Rutledge, Alliance, was named alternate for the same term.

Dr. McCallister reported that the Scientific Assembly was attended by 550 persons and that approximately 320 persons attended the banquet on September 16.

Eighth District Elects Officers At Rocky Glen Meeting

The annual meeting of the Eighth District Medical Society, held at Rocky Glen Sanatorium on August 28, drew an attendance of 123 guests, including doctors from the Eighth District, Health Department nurses and Tuberculosis Association workers from various counties. There were also representatives from the Brotherhood of Railroad Trainmen and the United Mine Workers.

The program was according to schedule with the exception of the talk by Dr. Louis Friedman, of Birmingham, Ala., who was unable to be present because of illness. In his place, Robert Secrest, U. S. Representative from the 15th Congressional District, gave a short address, stressing his opposition to socialized medicine, and pledging that he would at all times resist any efforts to bring it about.

Hosts for the occasion were Dr. Louis Mark, medical director of the Sanatorium and members of his staff. A buffet luncheon was served after the program.

Newly elected officers of the Eighth District Medical Society are the following: Dr. William L. Denny, Cambridge, president; Dr. Reo M. Swan, Cambridge, vice-president; Dr. Charles F. Shively, Cambridge, secretary-treasurer. Dr. Robert S. Martin, Zanesville, is Councilor of the Eighth Councilor District.

Medical Books Are Needed by Profession in Israel

Physicians interested in the project are invited to send medical books of educational value for use by physicians, hospitals and universities of Israel. Any books in good condition, published since 1940 will be appreciated. Books superseded by newer editions are welcomed.

Books should be sent prepaid parcel post "book rate" (up to 70 pounds per package) to: Books for Israel, 115 King Street, New York 1. Funds for shipment overseas are provided under the government's Point IV program.

Third-Generation Physician Receives Degree

Dr. Robert B. Elliott, now interning in Charity Hospital, New Orleans, is the third generation of Elliotts to practice medicine. His grandfather, the late Dr. S. H. Elliott, practiced in Ada until his death in 1930. His father, Dr. Floyd M. Elliott, has been a practicing physician in Ada since the 1920's.

The young Dr. Elliott graduated from the University of Cincinnati College of Medicine in June. He recently had published in the *Journal of Criminal Law, Criminology and Political Science*, a paper on the value of roentgenology in identification of mutilated and burnt bodies.

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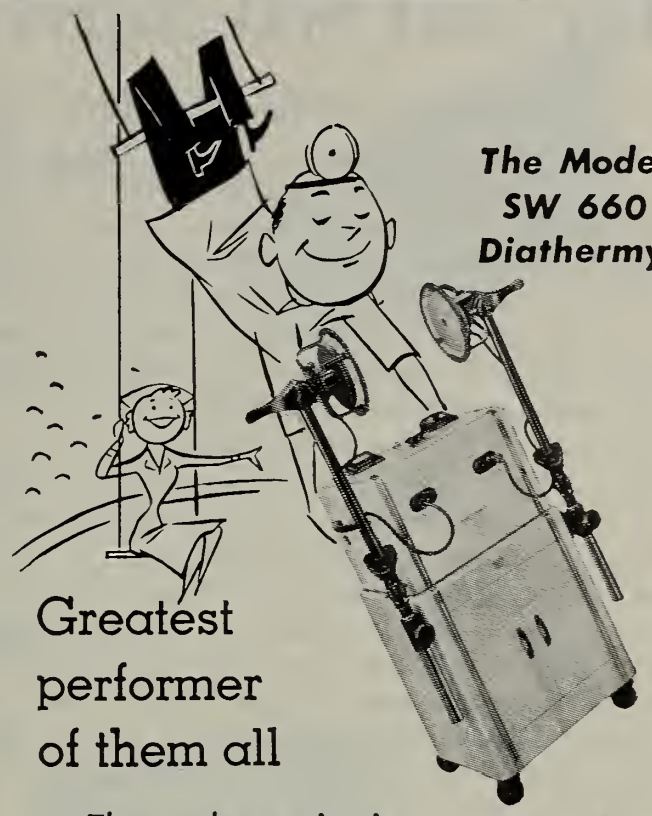
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Buy and Sell Agreement . . .

Contract Between Older Physician and Younger Associate. Based On Insurance, Will Meet Problems Arising From Death of Either

A PROBLEM exists in many cases where doctors have associated themselves in the practice of medicine. The basis on which they work may be a partnership, it may be an employer-employee relationship or it may be simply a completely informal relationship to save expense and duplication of equipment.

Very many times, the men involved consist of a well established elder doctor, who is beginning to look toward retirement, and a young man whose future is ahead of him. The elder man wants a way to pass on to his family, should he die, as much as possible of the value of his practice, and the younger man wants to know he is establishing his reputation in a spot where he will continue to work, and that he will not have to start over in some new area.

VALUE IN GOOD WILL

It is exactly the problem found in any business, with this exception: Only a small portion of a doctor's value is in the form of tangible property. Much of it is in the form of good will—years of faithful, expert service. This good will is reflected, to a large extent, in the habit which patients have of going to a certain office, where they have known satisfaction. (The sale of medical practices illustrates this point.) This good will should and can be preserved for his successor.

One good plan to accomplish this is to have a buy and sell agreement with an associate, so that at his death there is a ready purchaser at an agreed price. If it is not possible to set a price, a method of determining a fair price at death is included in the agreement.

ITEMS OF AGREEMENT

The items necessary in one such agreement are outlined below:— **(The actual agreement should be drawn by a lawyer.)**

(1) Agreement to Sell and Buy. Dr. Younger agrees to purchase, and the Estate of Dr. Elder agrees to sell said medical practice, etc., as defined in No. 5 below.

(2) Price—$25,000 or amount equal to ½ professional fees collected by Dr. Elder in last calendar year, whichever is greater.

(3) Payment—Dr. Younger shall pay full purchase price to Dr. Elder's estate within 60 days after Dr. Elder's death. If purchase price is in excess of $25,000—then Dr. Younger delivers his promisory note to the estate of Dr. Elder, payable within 12 months at 4 per cent interest for excess of purchase price over $25,000.

(4) Delivery—Upon payment of purchase price, the estate shall deliver to Dr. Younger the subject of this sale.

Editor's Note: The accompanying article was submitted to *The Journal* by a member of the Ohio State Medical Association, thinking it might be helpful to physicians associated in practice. He states that the set-up described was worked out for him in his association with another physician by a chartered life underwriter and appears to be sound in every respect.

SUBJECT OF SALE

(5) Subject of Sale—The subject of this sale shall be full title and interest of Dr. Elder in his medical practice together with good will, professional equipment and furnishings. (If there are any exclusions they should be listed.) Included should be medical records for some period, and access to such records made over some longer period.

(6) Dr. Younger shall secure and maintain a policy of insurance on Dr. Elder's life in an amount not less than $25,000. Dr. Younger shall be sole owner of policy, but shall have no right to withdraw any policy nor to modify or impair any of the rights under such policy.

TERMINATION OF AGREEMENT

(7) Termination of Agreement—The agreement shall terminate upon the occurrence of any of the following events:—

(a) Death of Dr. Elder.

(b) Death of Dr. Younger, whereupon Dr. Elder may purchase any policy at its then cash value.

(c) The death of both Dr. Elder and Dr. Younger within a period of ten days. Proceeds of policy to the estate of Dr. Younger, and full title to practice remains in Dr. Elder's estate.

(d) Termination of association of Dr. Elder and Dr. Younger, whereupon Dr. Elder may purchase any policy at its then cash value.

HAS BEEN USED

This particular contract was used between an older doctor who employed a younger doctor on a salary basis. The younger man's salary was increased to pay premiums on policy, and this became a deductible item on older man's tax. The younger man paid tax on this increase in his salary.

The same type of agreement may be modified to meet any given relationship.

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CO-SALT CONTAINS NO LITHIUM . . . is not bitter, metallic, or disagreeable in taste. It is the only salt substitute that contains choline.

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Licenses Granted . . .

Results of June 15-17 Examinations of State Medical Board Announced; Total of 301 Doctors of Medicine Certified To Practice in the State

RESULTS of the examinations conducted by the State Medical Board of Ohio on June 15-17 were considered by the Board at its meeting held on August 25.

A total of 301 graduates of Schools of Medicine were authorized certificates to practice medicine and surgery. In addition, 63 graduates of osteopathic schools were authorized to receive certificates to practice osteopathic medicine and surgery.

In the limited branches of practice, certificates were authorized to be awarded to 48 chiropodists, 9 mechanotherapists, 10 chiropractors, 21 masseurs and 3 cosmetic therapists.

Highest grade in the medical examinations was made by Paul R. Henry, Cincinnati, graduate of the University of Cincinnati College of Medicine, with an average of 89.2 per cent.

A close second of 89.1 per cent was made by Bernard Panner, Youngstown, graduate of Western Reserve University School of Medicine.

Two candidates tied for third place with 88.8 per cent each. They are Philip D. Sloan, Jr., Cleveland, a graduate of Western Reserve, and Willard S. Krabill, near Louisville (Ohio), a graduate of Jefferson Medical College.

Following is the list of those granted licenses to practice medicine and surgery in Ohio, with the medical school of graduation and residence stated at time of examinations:

OHIO STATE UNIVERSITY—Bruce F. Andreas, Cleveland Heights; Saul P. Baker, Cleveland; Charles R. Bammerlin, Fresno, Calif.; Raymond E. Barker, Columbus; Max Benis, Cleveland Heights; Fred A. Bower, Uhrichsville; Albert M. Bringardner, Columbus; David Spencer Brown, Chillicothe;

Douglas H. Castleman, Grand Rapids, Mich.; David J. Chesler, Columbus; Joseph M. Claunch, Columbus; Francis A. Cleary, Akron; Nino M. Camardese, Steubenville;

Fred R. Denkewalter, Columbus; William Dorner, Jr., Akron; George T. Drake, Columbus; Jane C. Fitz, Worthington; Jack M. Freeder, Akron; Arnold B. Friedman, Cleveland; Seymour Friedman, University Heights; Charles R. Fuchs, Sandusky;

Robert A. Gerrick, Wakeman; James C. Good, Columbus; Cyrus T. Greene, Columbus; John R. Greene, East Liverpool; Robert A. Gwinner, New Philadelphia;

Jack Haldeman, Columbus; Samuel C. Hardy, Wellington; Harry W. Haverland, Mineral Ridge; Jack Sherwin Hirsch, South Euclid; Walter A. Holbrook, Columbus; Paul E. Howard, Akron;

Richard L. Jackson, Columbus; James E. Kackley, Buffalo (Ohio); John Kemph, Columbus; William J. Kerth, Miamisburg; Stella B. Kontras, Columbus; Ralph D. Lausa, Columbus; Julian S. Lewis, Cleveland Heights; Dale K. Lindberg, Hartville; Charles E. Long, Columbus; Robert J. Lutz, Columbus;

James R. Manchester, Lakeview; Jack Marks, Youngstown; Paul T. Menzies, Dayton; Richard T. Messick, Ashville; Edward M. Miller, Jr., Youngstown; Emmett P. Monroe, Cuyahoga Falls; Robert C. Myers, Cleveland;

Irving A. Nickerson, Columbus; Raymond D. Nichols, Toledo; Kathryn P. Noble, Columbus; Richard L. Orders, Columbus; William R. Oris, Fairport Harbor;

Landon L. Palmer, Knoxville, Tenn.; Eugene H. Peck, Springfield; Louis S. Pollens, Detroit, Mich.; Jack R. Postle, Columbus; Frederick M. Rarick, Orient; John E. Rhodenbaugh, Akron; Herschel A. Rhodes, Tallmadge; Frederick I. Rose, Columbus; Revelle Russell, Fairborn;

Peter P. Saroff, Toledo; Louis M. Schoettle, Dayton; Victor M. Shampton, Dayton; Ernest G. Sheehan, Cambridge; Richard F. Slager, Columbus; Ned A. Smith, Wapakoneta; Richard H. Smith, Columbus; John R. Strawsburg, Dayton; Robert J. Swindaman, Toledo;

Emery E. Ulrich, Carey; Dorothy M. Van Ausdal, Lewisburg; Andrew Veg, Alliance; Donald H. Volzer, Jr., Canton;

Glen Wagner, Westerville; James E. Walters, Ada; John R. Webb, Nelsonville; Sanford R. Weiss, Youngstown; Paul M. Whetstone, Columbus; C. Craig Wright, Winterset; Gene E. Wright, Grand Rapids, Mich.; Bobby D. Young, Crooksville.

UNIVERSITY OF CINCINNATI—James E. Arnot, Cincinnati; James W. Barnes, Middletown; Charles A. Browning, Jr., Falmouth, Ky.; John A. Brunsman, Cincinnati; Robert C. Burt, Cincinnati; Paul A. Busam, Cincinnati; Thomas G. Byrne, Hamilton;

Emmett E. Campbell, Jr., Dayton; John F. Cardosi, Cincinnati; Richard D. Carr, Monticello, Ind.; Robert E. Cassidy, Covington, Ky.; Norman E. Chase, Cincinnati; Clarence G. Clarkson, North Vernon, Ind.; Frank Clement, Cincinnati; Henry G. Cramblett, Scio;

Howard A. Dillon, Cuyahoga Falls; Donald K. Ebersold, Cincinnati; David W. Elliott, Cincin-

nati; Robert B. Elliott, Ada; Frank E. Ellis, Cincinnati;

Hugh J. Forthman, Cincinnati; John P. Fox, Loveland; Thomas E. Fox, Lancaster; Robert C. Fraasa, Cincinnati; Ellsworth L. Friedley, New Washington; Alvin Friedman, Cincinnati;

James W. Goettle, Cincinnati; Milton M. Goldfarb, Cincinnati; Duane B. Heilbrann, Cincinnati; Donald J. Heimbrock, Cincinnati; Robert G. Heimbrock, Covington, Ky.; Paul R. Henry, Cincinnati;

Harold E. Jakes, Cincinnati; Don R. Johnson, Cincinnati; Jack R. Kirschner, Cincinnati; Frank LaCamera, Jr., Warren;

Paul F. MacCarter, Jr., Cincinnati; Frederick T. Martin, Cincinnati; Robert E. McCorkle, Cincinnati; David McKell, Cincinnati; William J. D. Mersch, Covington, Ky.; Max I. Michels, 1st Lt. El Paso, Texas; Don H. Mills, Cincinnati; Richard Y. Moon, Philadelphia, Pa.; Edward D. Morris, Jr., Cincinnati;

William J. Novak, Perintown; George R. Nugent, Durham, N. C.; Robert W. O'Conner, Covington, Ky.; Gilbert K. Ohlhauser, Cincinnati; Charles L. Oppy, Springfield; Barney Osborne, Jr., Ironton;

William E. Peterson, Cincinnati; Nathan Polasky, Cincinnati; William M. Porter, Dayton; Robert C. Price, Jr., Cincinnati; Gerard Rawle, Highland Park, Mich.; Robert R. Renner, Cleveland Heights; Ralph W. Richter, Cincinnati; Martin A. Rush, Jr., Middletown;

John A. Schadler, Cincinnati; John W. Schaefer, Cincinnati; Richard Schaengold, Hamilton; Frank J. Scharold, Jr., Cincinnati; Jack D. Selzer, Cincinnati; Paul E. Smalley, Ft. Thomas, Ky.; Alexander T. Smith, Hanover, N. H.; George D. Smith, Hamilton; Richard L. Smith, Hamilton; Jack L. Stauf, Columbus; Richard J. Stenger, Cincinnati; Arthur J. Stevenson, Hubbard;

Wilbur A. Taylor, Jr., Toledo; John L. Thinnes, Jr., Cincinnati; Donald R. Thomas, Cincinnati; Gene Milton Thompson, Cincinnati; Frank E. VonHolle, Cincinnati;

Robert V. Wade, Dayton; Elmer L. Wallace, Cincinnati; William R. Whitaker, Cincinnati; John E. Williams, Cincinnati; Jerome F. Wiot, Cincinnati; Walter J. Wolf, Cincinnati; John M. Wolfe, Cincinnati; George A. Woodhouse, Jr., Wyoming; Richard T. Wurzelbacher, Cincinnati.

WESTERN RESERVE UNIVERSITY—Robert B. Allport, Cleveland; Albert E. Baldwin, Jr., Cleveland; John R. Bay, Alliance; Daniel C. Beittel, Cleveland; Charles M. Branden, Cleveland; Richard E. Braucher, Cleveland; William H. Bunn, Jr., Youngstown;

Maxine R. Cammarn, Cleveland; William W. Carroll, Phoenix, Ariz.; Robert S. Caulkins, Jr., University Heights; Arthur C. Cherry, Jr., Cincinnati; Charles L. Christian, Cleveland; Don R. Clark, Lakewood; Charles M. Comella, Cleveland; Oswald H. Coury, Wheeling, W. Va.; John W. Cullen, Paulding; Charlotte D. Curtiss, Binghamton, N. Y.; Robert L. Custer, New Waterford;

Richard A. Diroll, Hubbard; James W. Ensign, Cleveland; Allen R. Evans, Cleveland; John R. Evans, Cleveland Heights; Ernest R. Felix, Cleveland; George D. Finlayson, Cleveland; Edwin S. Francis, Cleveland; Betty J. Fratianne, Cleveland Heights; George A. Freeman, Cleveland;

Sheldon G. Gaylin, East Cleveland; William Glasser, Los Angeles, Calif.; Ralph Herz, Jr., Key West, Fla.; Byron K. Hoffman, Cleveland; Clinton L. Holt, Phoenix, Ariz.; Joseph F. Kelley, Salem; Gordon E. Kibler, Toledo; Harry A. Killian, Ft. Worth, Texas;

James R. Lasch, Shaker Heights; Leo D. Lenkoski, Cleveland Heights; Grace E. Lindsay, Cleveland; Arthur J. Loman, Jr., Buffalo, N. Y.; Milton A. McDade, Dormont, Pa.; John R. McVey, Youngstown; David V. Morrison, Cleveland;

Raymond J. O'Brien, Cleveland; Robert D. Palmer, Cleveland; Bernard Panner, Youngstown; Ralph L. Perry, Cleveland; Harlan R. Peterjohn, Cleveland;

Alexander C. Reed, St. Louis, Mo.; DeWayne G. Richey, II, Cleveland; Thomas J. Roess, Cleveland; Saul A. Rosenberg, University Heights; Melvin B. Ross, Cleveland Heights; David Rubin, Cleveland Heights; Lee I. Rubinstein, Euclid;

Symon Satow, Cleveland; Janet Berman Sax, Toledo; George R. Scheid, York, Pa.; Rolland E. Scherbarth, Toledo; David W. Schultz, Lakewood; John H. Sheets, Chillicothe; Marvin D. Slavkin, Pittsburgh, Pa.; Philip Dutcher Sloan, Jr., Cleveland; George W. Smith, Jr., Waldo; Bella S. Strauss, Philadelphia, Pa.;

Charles R. Vaughn, Lakewood; Victor Vertes, Shaker Heights; Jacob Weintraub, Cleveland; Richard A. Wiant, Cleveland; Ian D. Wilson, Detroit, Mich.; Robert A. Wiltsie, Youngstown; Elmer McL. Wright, Cleveland; Albert M. Zippert, Cleveland.

OUT-OF-STATE—Virgil R. Boli, Greenville; Norman A. Hill, Cincinnati, Columbia University;

George F. Alter, Toledo, Duke University;

Raymond A. Klinger, Strasburg, Hahnemann Medical College;

Carl H. Cather, Jr., Morgantown, W. Va., Harvard; Carl F. BrandFass, Jr., Akron; William J. Duhigg, Cleveland Heights; Willard S. Krabill, Louisville, Jefferson Medical College; Earl W. Wharton, Cuyahoga Falls, Jefferson Medical College;

Kenneth W. Robinson, Youngstown; Paul J. Weiss, Toledo, Marquette University;

Clarence R. Higgins, Jr., Cleveland; Elver D. Lee, Cincinnati, Meharry Medical College;

Thomas P. Price, Jr., Cincinnati, Northwestern University;

Howard Thomas Baumgardner, Akron; Ralph J. Kovach, Cleveland; John D. Schirack, Canton;

Robert P. Yeager, Youngstown, Stritch Medical School;

Sylvan Raphael, Trenton, N. J., University of Chicago;

Robert C. Muehrcke, Cincinnati, University of Illinois;

Charles Glen Adkins, Coalwood, W. Va., University of Maryland;

Thomas B. Vest, Columbus, University of Pennsylvania;

Robert O. Walton, Pittsburgh, Pa., University of Pittsburgh;

Joseph F. Finelli, Rochester, N. Y.; Donald B. Polan, Cleveland; Daniel R. Rectanus, Middletown, University of Rochester;

Albert J. Molinaro, Cleveland, University of Wisconsin.

FOREIGN GRADUATES—Frederick William Rook, Kenmore, N. Y., University of Toronto;

Murray M. Bett, Youngstown; June M. Rees, Columbus, University of Edinburgh; James B. McMillan, Columbus, University of Glasgow;

Anthony Lelbach, Cleveland, University of Graz;

Antanas Cerskus, East St. Louis, Ill.; Antanas Miliauskas, Brooklyn, N. Y.; Leonard Plechavicius, New York, N. Y., University of Kaunas;

Mogens A. Plessen, New York, N. Y., University of Kiel; Erna M. Berzins, Laura; Velta F. Briuks, Oak Ridge, Tenn.; Gotholds Kalnins, Columbus; Indrikis E. Parups, Cleveland; Lothar Ramins, Woodward, Iowa; Janis S. Skrastins, Hamilton, University of Latvia;

Michael Jaremczyszyn, Lima, University of Lemberg;

Pauline M. Dean, Liverpool, England, University of Liverpool;

Alfred K. Bonk, Chicago, Ill.; Leonidas Romanowski, Cincinnati; Henry A. Thomas, Charlotte, N. C., University of Lwow;

Jacob Wacker, Louisville, Ky., University of Munich;

Miklos Paal, Wheeling, W. Va., University of Pecs; Mieczyslaw Peszcynski, New York, N. Y., University of Poznan; Joseph O. Fikar, Washington, D. C., University of Prague;

Rudolph Bognar, Cleveland; Ferenc M. Freimann, Cleveland, University of Szeged;

Francis J. Harvey, Elmhurst, N. Y.; Josef Sanger, Cincinnati, University of Vienna;

Celina D. Borowska, Cincinnati, University of Warsaw;

Zoltan Szalontay, Wheeling, W. Va.; Ivan Tuskan, Cincinnati; Frederick M. Zerzavy, Baltimore, Md., University of Zagreb;

Anton Gintner, Cleveland, University of Budapest.

Office Public Relations For the Busy Physician

Editor's Note: In order to provide tips for physicians in regard to good Public Relations procedures and practices in their offices, *The Journal* will present from time to time concise articles based on suggestions and recommendations made at A. M. A. Public Relations conferences and on articles published in other medical journals.

WAYS TO RUIN A PRACTICE

The Editor of the *Detroit Medical News* pointed up some mighty important matters having a bearing on physician-patient relationships in the following piece which carried the heading, "Ten Ways To Ruin a Practice":

"Certain practices that estrange patients and place the profession in an unfavorable light have inadvertently filtered into present-day medical practice. Most of these are known, having been called to our attention by a critical public that holds each of us to close limits of conduct.

"Here are a few practices that can ruin any practice:

"1. Disappearing whenever the mood strikes us and otherwise making ourselves as unavailable as possible.

"2. Making no pretense about keeping appointments and keeping patients waiting in the belief that they will thus appreciate us more.

"3. Prescribing by ear and without regard to cost, not taking the time to diagnose or to plan treatment beforehand.

"4. Being as impersonal as possible and brushing patients off quickly so they can't ask questions.

"5. Sparing no one's feelings in discussing prognosis—giving it to 'em straight and walking off.

"6. Failing to plan for patients who are hospitalized, and having no regard for the length of stay or its cost.

"7. Labelling the problem patient a neurotic and punishing him if he fails to respond to treatment.

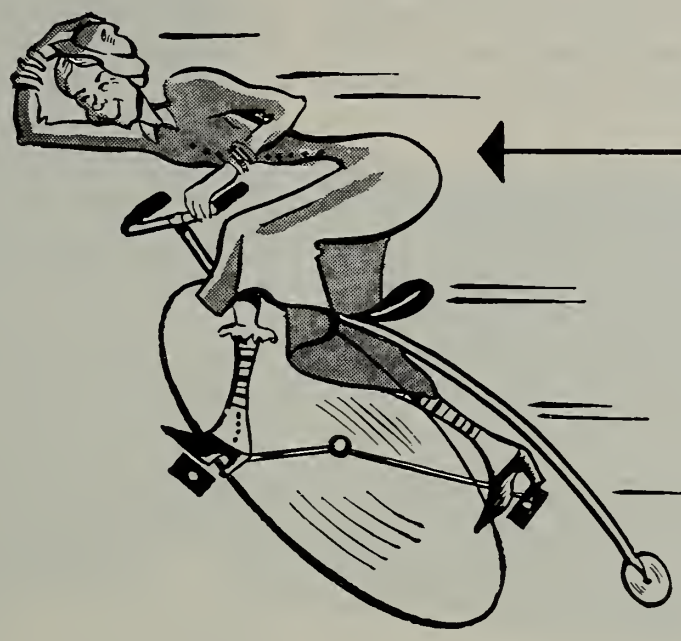
"8. Blowing our tops often to impress the patient with our maturity.

"9. Keeping no records but relying solely on memory.

"10. Charging all the traffic will bear.

"We must constantly keep before us these errors that invite distrust and reduce our usefulness. Even though there is an abundance of practice we cannot afford to alienate our public."

Times change



but the mark of a good
pharmaceutical house

PAUL B. ELDER CO. BRYAN, OHIO

is remembered for generations

Medical Education Foundation . . .

Campaign To Support Medical Schools Again Will Be Promoted in Ohio This Fall; Up-To-Date List of County Committee Chairmen Is Given

OHIO physicians again have an opportunity this Fall to support the nation's medical schools through contributions to the 1953 campaign of the American Medical Education Foundation.

The A. M. E. F. was founded by the American Medical Association in 1951 when it appeared imperative that the medical profession had to assume responsibility for assisting the medical schools to overcome their serious financial difficulties, and for maintaining high standards of medical education.

During the past three years, the Foundation, together with the National Fund for Medical Education, has made unrestricted grants totaling $4,764,052.64 to the schools. The National Fund solicits donations from corporations and lay groups. That amount includes a distribution of $1,944,151.64 in July, 1953.

Dr. William M. Skipp, Youngstown, is chairman of the Ohio Campaign Committee, which is composed of the 11 District Councilors of the Ohio State Medical Association. Councilors have appointed county chairmen in their respective districts after consultation with the local medical society presidents.

INITIAL APPEAL

An initial appeal to support the Foundation will be in the form of a letter in October from Dr. Paul A. Davis, President of the State Association. This will be followed up by personal solicitation by the county chairmen.

This state-wide effort to assist the medical schools in their financial difficulties is not meant to be in competition with the fund-raising efforts of individual schools. The Ohio Committee hopes that physicians who have been making donations to their own schools will continue to do so. Furthermore, gifts through the Foundation may be designated for a particular school, and they will be added to the school's basic grant from unearmarked funds.

During 1952, a total of 2,922 Ohio physicians made financial contributions to medical schools, according to the second annual report of the S. M. E. F. Of that number, 1,657 donated directly to their medical schools and 265 contributed through the Foundation.

Dr. Skipp and the members of his committee are hopeful that previous contributors will repeat this year, and that many more Ohio physicians will rally to the support of such a worthy cause.

Following is a list of the county chairmen for the 1953 campaign in Ohio of the American Medical Education Foundation:

FIRST DISTRICT

ADAMS—Kurt E. Platschik, Manchester.
BROWN—Donald L. Domer, Georgetown.
BUTLER—Clyde G. Chamberlin, Hamilton.
CLERMONT—George E. Rockwell, Milford.
CLINTON—Nathan S. Hale, Wilmington.
HAMILTON—Stanley W. Whitehouse, Cincinnati.
HIGHLAND—Henry H. Lowe, Leesburg.
WARREN—Frank H. Batsche, Mason.

SECOND DISTRICT

CHAMPAIGN—F. E. Lowry, Urbana.
CLARK—Paul W. Schanher, Springfield.
DARKE—E. W. Browne, Greenville.
GREENE—Ray W. Barry, Xenia.
MIAMI—W. T. Wilkins, Piqua.
MONTGOMERY—M. D. Prugh, Dayton.
PREBLE—E. P. Trittschuh, Lewisburg.
SHELBY—John H. Kerrigan, Sidney.

THIRD DISTRICT

ALLEN—Walter A. Noble, Lima.
AUGLAIZE—David W. Nielsen, Waynesfield.
CRAWFORD—L. A. Swinehart, Bucyrus.
HANCOCK—Henry P. Koehler, Findlay.
HARDIN—Norman C. Schroeder, Kenton.
LOGAN—Clyde K. Startzman, Bellefontaine.
MARION—Philip W. Smith, Marion.
MERCER—M. G. Harnick, Coldwater.
SENECA—Paul J. Leahy, Tiffin.
VAN WERT—Roland H. Good, Van Wert.
WYANDOT—F. M. Kenan, Upper Sandusky.

FOURTH DISTRICT

DEFIANCE—Richard A. Cunningham, Defiance
FULTON—C. F. Murbach, Archbald.
HENRY—John J. Harrison, Napoleon.
LUCAS—Maurice A. Schnitker, Toledo.
OTTAWA—C. R. Wood, Port Clinton.
PAULDING—Doyt E. Farling, Payne.
PUTNAM—Arthur P. Daniel, Ottawa.
SANDUSKY—Leo A. Pokerr, Fremont.
WILLIAMS—William L. Hann, West Unity.
WOOD—F. F. Price, Stony Ridge.

FIFTH DISTRICT

ASHTABULA—Adelbert M. Mills, Ashtabula.
CUYAHOGA—C. J. Vogt, Cleveland.
GEAUGA—Alton W. Behm, Chardon.
LAKE—Alfred C. Mahan, Willoughby.

SIXTH DISTRICT

COLUMBIANA—Chester W. Dewalt, Columbiana.
MAHONING—Wm. M. Skipp, Youngstown.
PORTAGE—Robert M. Dumm, Kent.
STARK—James E. Purdy, Canton.
SUMMIT—Alven M. Weil, Akron.
TRUMBULL—M. J. Knappenberger, Warren.

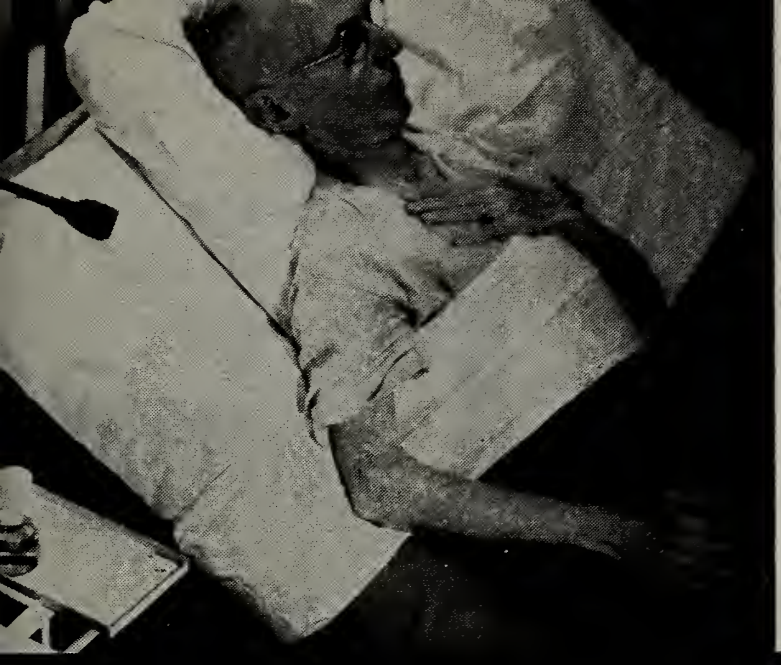
SEVENTH DISTRICT

BELMONT—David Danenberg, Bridgeport.
CARROLL—Carl A. Lincke, Carrollton.
COSHOCTON—Gerald A. Foster, Coshocton.
HARRISON—D. L. Tippett, Cadiz.
JEFFERSON—Jacob Mervis, Steubenville.
MONROE—A. R. Burkhart, Woodsfield.
TUSCARAWAS—D. H. Downey, Dover.

EIGHTH DISTRICT

ATHENS—E. L. Schmidt, Athens.
FAIRFIELD—William S. Jasper, Pleasantville.
GUERNSEY—James A. Toland, Cambridge.
LICKING—Paul N. Montalto, Newark.
MORGAN—Henry Bachman, Malta.
MUSKINGUM—Clyde G. Sussman, Zanesville
NOBLE—Edward G. Ditch, Caldwell.
PERRY—O. D. Ball, New Lexington.
WASHINGTON—J. B. Penrose, Marietta.

(Continued on page 938)



Terramycin®

BRAND OF OXYTETRACYCLINE

an agent of choice in urinary tract infections

- *promptly effective against a broad-spectrum of urinary pathogens*
- *high concentration in active form in urinary tract*
- *well tolerated, even upon prolonged administration*

Terramycin
is acclaimed
by urologists everywhere
for unsurpassed action in

chronic urinary tract infections

acute urinary tract infections

urinary tract surgery

"The resistant cases showed remarkable response."[1]
". . . has cured where all other antibiotics have failed."[2]

"Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[3]

"Morbidity from apparent genito-urinary causes was noted in only one patient of 44 patients who received prophylactic Terramycin."[3]

"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[2]

1. Ferguson, C., and Miller, C. D.: J. Urol. *67*:762 (May) 1952.
2. Trafton, H. M., and Lind, H. E.: Ibid. *69*:315 (Feb.) 1953.
3. Blahey, P. R.: Canad. M. A. J. *66*:151 (Feb.) 1952.

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DIVISION, CHAS. PFIZER & CO., INC.

NINTH DISTRICT

GALLIA—Oscar W. Clarke, Gallipolis.
HOCKING—John W. Doering, Logan.
JACKSON—William T. Washam, Jackson.
LAWRENCE—A. J. Payne, Ironton.
MEIGS—Roger P. Daniels, Pomeroy.
PIKE—G. W. Cooper, Piketon.
SCIOTO—William J. Hartlage, Sciotoville.
VINTON—H. D. Chamberlain, McArthur.

TENTH DISTRICT

DELAWARE—George D. Blydenburgh, Delaware.
FAYETTE—Hugh W. Payton, Jeffersonville.
FRANKLIN—Richard L. Meiling, Columbus.
KNOX—Robert H. Hoecker, Mt. Vernon.
MADISON—J. A. Knapp, London.
MORROW—William Lowell Murphy, Cardington.
PICKAWAY—Ned B. Griner, Circleville.
ROSS—William M. Garrett, Frankfort.
UNION—Harold E. Stricker, Marysville.

ELEVENTH DISTRICT

ASHLAND—Howard R. Wetzel, Ashland.
ERIE—Emil J. Meckstroth, Sandusky.
HOLMES—N. P. Stauffer, Millersburg.
HURON—George F. Linn, Norwalk.
LORAIN—A. C. Siddall, Oberlin.
MEDINA—Thomas V. Kolb, Litchfield.
RICHLAND—Paul A. Blackstone, Mansfield.
WAYNE—L. A. Adair, Wooster.

New Members of O. S. M. A.

The following are the names of new members of the Ohio State Medical Association since August 5, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

COSHOCTON COUNTY

Carpenter, Lawrence O., Coshocton

CUYAHOGA COUNTY

Anderson, Norma, Cleveland
Bidder, Thomas G., Cleveland
Boehmer, Henry E., Cleveland
Campbell, Leland E., Cleveland
Epstein, Bernard D., Cleveland
Hacker, Vernon D., Cleveland
Hadbavny, Lawrence T., Cleveland
Hall, Alvin P., Cleveland
Hollenberg, Barbara, Cleveland
Levy, Richard P., Cleveland
Persky, Lester, Cleveland
Riff, Emmanuel R., Cleveland
Schraff, Albert G., Cleveland
Singerman, Richard C., Cleveland
Skur, Anthony, Cleveland
Taylor, Leslie C., Cleveland
Wertenberger, George F., Parma
Wise, Robert E., Pittsburgh, Pa.

FRANKLIN COUNTY

Burchfield, John F., Columbus
Myers, Theodore S., Columbus
Rosemond, John H., Jr., Columbus
Sinclair, Robert E., Columbus
Tomashefski, Joseph F., Columbus

GALLIA COUNTY

Biber, Jakub J., Gallipolis
Burner, Ralph B., Gallipolis
Fleming, Arthur R., Gallipolis
Jiroch, John T., Gallipolis

JEFFERSON COUNTY

Hetey, Stephan, E., Dillonvale
Myers, Donald, Wintersville

LUCAS COUNTY

Alter, Robert, Toledo
Crider, Ernest, Toledo
Larzelere, Henry, Toledo
Rost, Elmer, Jr., Toledo
Schecter, Jack, Toledo

MONTGOMERY COUNTY

Colglazier, Jack, Dayton
Doherty, Wm. R., Dayton
Graubarth, Harry, Dayton
Mendelson, Janice, Dayton
Meyer, Gerald, Dayton
Stuhlman, O. H., West Milton

OTTAWA COUNTY

Hughes, Patrick, Port Clinton
Ritter, F. Kraft, Port Clinton

SCIOTO COUNTY

MacDonald, Jack, Portsmouth
Woodyard, Richard, Friendship

WOOD COUNTY

Roberts, Wm. H., North Baltimore



Wide Medical Interest in New Knox Gelatine "Eat and Reduce" Plan

Developed and supervised by competent clinical authority, the new Knox "Eat and Reduce" Plan is intended especially for your overweight patients in otherwise normal health.

The plan has been tested on overweight patients with fine results. In addition, many physicians (and their families) have written us about their gratifying personal results with this plan.

The Knox "Eat and Reduce" Plan is a simple, sensible regimen that places no burden of exercise or hunger on the patient. Quite the contrary, it permits three tempting, solid meals daily, plus between-meal feedings. The menus have been carefully selected so as to provide an abundance of vitamins, minerals and protein. Many of the dishes utilize Knox Gelatine, which is, of course, all protein and no sugar — thus being an effective aid in weight reduction.



AVAILABLE AT GROCERY STORES
IN 4-ENVELOPE FAMILY SIZE AND
32-ENVELOPE ECONOMY SIZE PACKAGES.

Knox Gelatine U.S.P.
ALL PROTEIN NO SUGAR

USE THIS COUPON! ***Write today!***
Knox Gelatine, Johnstown, New York Dept. O S

Please send me FREE copies of the "Eat and Reduce" Plan, and Diets.

Name..... M.D.

Address.....

City..... Zone..... State.....

Postgraduate Course . . .

Bunts Institute, Cleveland, Announces Refresher Course in General Surgery To Be Conducted at the Cleveland Clinic, October 28 and 29

THE FRANK E. BUNTS Educational Institute of the Cleveland Clinic Foundation has announced the following tentative program for a postgraduate continuation course to be given Wednesday and Thursday, October 28 and 29:

WEDNESDAY MORNING, OCT. 28

Dr. R. S. Dinsmore, Presiding

8:30 - 9:00 a. m.—Registration.

9:00 - 9:05—Opening Remarks, Dr. Dinsmore.

9:05 - 10:30—Head, Neck and Thyroid:

1. Trends in Thyroid Surgery, Dr. Dinsmore.
2. The Present-Day Therapy of Hyperthyroidism, Dr. E. P. McCullagh.
3. Tumors of the Thyroid and Thyroiditis, Drs. George Crile, Jr., and J. B. Hazard.
4. Surgical Management of Tumors of the Head and Neck, Dr. Robin Anderson.

10:30 - 12:00 noon—Surgery of Heart and Lungs:

1. Selection of Patients for Mitral Commissurotomy, Dr. A. C. Ernstene.
2. Surgical Aspects of Mitral Commissurotomy, Dr. D. B. Effler.
3. Indications for Lung Biopsy and Pulmonary Exploration, Dr. H. S. Van Ordstrand.
4. Selection of Patients for Surgery of Cardiac Anomalies, Dr. F. M. Sones, Jr.
5. Special Problems in Anesthesia for Operations upon Heart and Lungs, Dr. C. E. Wasmuth.

12:15 p. m.—Luncheon, Courtesy Bunts Institute.

WEDNESDAY AFTERNOON, OCT. 28

Dr. R. B. Turnbull, Jr., Presiding

1:30 - 2:30 p. m.—Diseases of Biliary Tract and Pancreas:

1. Indications for Surgery of the Gallbladder, Dr. R. S. Dinsmore.
2. Surgery of the Pancreas, Dr. S. O. Hoerr.
3. Problems in Cholelithiasis, Dr. A. H. Robnett.
4. Hepatitis and Liver Biopsy, Dr. H. R. Rossmiller.

2:30 - 4:30—Diseases of Esophagus, Stomach and Duodenum:

1. Cancer of Upper Third of Esophagus, Dr. Eugene M. Bricker, associate professor of surgery, Washington University, St. Louis, Mo.
2. Hiatus Hernia, Dr. D. B. Effler.

Intermission.

3. Panel Discussion, Dr. S. O. Hoerr, moderator, and Drs. Bricker, Crile and C. H. Brown.

5:30—Dinner, courtesy Bunts Institute.

EVENING LECTURE

7:00 p. m.—Consideration for Extended Surgery for Abdominal and Pelvic Cancer, Dr. E. M. Bricker.

THURSDAY MORNING, OCT. 29

Dr. S. C. Hoerr, Presiding

9:00 a. m. - 12:00 noon—Miscellaneous Problems.

1. Cancer of the Cervix, Dr. J. S. Krieger.
2. Medical Aspects of Sterility, Dr. J. R. Cook.
3. The Discharging Nipple, Dr. A. H. Robnett.
4. Problems of Plastic Surgery, Dr. Robin Anderson.
5. The Injured Hand, Dr. G. S. Phalen.
6. Indications for Adrenalectomy, Dr. E. F. Poutasse.
7. What's New in Neurosurgery, Dr. W. J. Gardner.

12:15 p. m.—Luncheon, courtesy Bunts Institute.

THURSDAY AFTERNOON, OCT. 29

Dr. George Crile, Jr., Presiding

1:30 - 3:00 p. m.—Panel Discussion—Diseases of Small Intestine and Colon, Dr. George Crile, Jr., Moderator; Drs. E. M. Bricker, R. B. Turnbull, Jr., E. N. Collins and L. J. McCormack.

3:00 - 3:10—Intermission.

3:10 - 4:30 p. m.—Panel Discussion—Peripheral Vascular Disease, Dr. F. A. LeFevre, Moderator; Drs. V. G. deWolfe, D. C. Humphrey, W. J. Gardner and A. H. Robnett.

Two Ohioans on Committee to Advise Globulin Evaluation Group

Two Ohioans have been named on an advisory committee comprised of 17 persons whose purpose is to guide a nation-wide cooperative research effort to evaluate the use of gamma globulin against poliomyelitis. The program is sponsored by the U. S. Public Health Service in collaboration with the Association of State and Territorial Health Officers, the American Physical Therapy Association and the D. T. Watson School of Physiatrics, affiliated with the University of Pittsburgh School of Medicine.

Named on the advisory committee are Dr. John D. Porterfield, director of the Ohio Department of Health, and Dr. Albert B. Sabin, director of the Children's Hospital Research Foundation, Cincinnati.

A Wise Choice Against Resistant Cocci

ERYTHROCIN



a selective antibiotic



A DRUG OF CHOICE

against the majority of coccic infections—especially when patients are sensitive to other antibiotics or the cocci are resistant.



ADVANTAGEOUS

because the special acid-resistant coating, developed by Abbott, and Abbott's built-in disintegrator, assure rapid dispersal and absorption in the upper intestinal tract.



A DRUG OF CHOICE

against staphylococci—because of the high incidence of staphylococcic resistance to other antibiotics.



Prescribe ERYTHROCIN

in pharyngitis, tonsillitis, otitis media, sinusitis, bronchitis, pneumonia, scarlet fever, erysipelas, pyoderma, certain cases of osteomyelitis, and other indicated conditions.

Abbott



A DRUG OF CHOICE

because it is less likely to alter normal intestinal flora than other oral antibiotics, except penicillin; gastrointestinal disturbances are rare; no serious side effects reported.

* *Trade Mark for*

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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

FINDINGS of survey published by U. S. Chamber of Commerce disclose appreciable gains in 1952 by companies writing medical, surgical and hospital care insurance. Insurance in force at the close of 1952 included:

Hospital insurance—10,090,000 policyholders and their 12,164,000 dependents—a three per cent gain.

Surgical expense insurance—7,710,000 policyholders and their 11,486,000 dependents—a 17 per cent gain.

Medical coverage insurance—2,411,000 and their 2,709,000 dependents—a 21 per cent gain.

These figures do not include membership in voluntary plans such as Blue Cross-Blue Shield, nor enrollment through group insurance.

* * *

Major General Paul H. Streit, recently retired from the Army Medical Corps, has been appointed area administrator of the Johnstown, Pennsylvania office of the United Mine Workers Welfare and Retirement Fund. General Streit's last position was as commanding general of Walter Reed Hospital and Medical Center.

* * *

Annual report on United Mine Workers' Welfare and Retirement Fund reveals that $56,444,329.78 was spent for medical care and hospitalization in fiscal year ending June 30.

* * *

Internal Revenue Service has ruled that a blood donor may not deduct the market value of his contribution as a charitable gift when he is computing his income tax.

* * *

A two-months investigation of amyotrophic lateral sclerosis on the island of Guam has been started cooperatively by the Departments of Navy, Interior, and Health, Education and Welfare.

* * *

Rear Admiral Arthur H. Dearing, a former chief of naval medical personnel, is new executive secretary of the College of American Pathologists.

* * *

Dr. Edwin J. Rose, who received his medical degree from the Ohio State University School of Medicine in 1917, has become manager of the Mt. Alto Veterans Hospital in Washington, D. C. Dr. Rose was formerly assistant director of the hospital operations service in Washington office of the V. A.

Starting October 1, Colonel Wayne G. Brandstadt, recently retired from the Army, will become assistant editor of *The Journal of the American Medical Association.*

* * *

Breakdown of Veterans Administration budget for fiscal year that began July 1 discloses total of $32.6 million available for fee-basis medical and dental care.

* * *

The Commission on Chronic Illness has begun a year-long study in Baltimore, designed to provide data which will assist communities in problems of care and rehabilitation of the chronically ill.

* * *

Bureau of Internal Revenue has ruled that sums paid to psychologists for health services are deductible on same basis as ordinary medical expenses.

* * *

Federal Trade Commission has promulgated new trade practice rules for hearing aid industry, their first revision since 1944. Some of the rules are: (1) Marketers will refrain from stating or implying that a hearing aid has been designed or manufactured with medical advice if such is not the case; (2) They must not use the terms "specialist," "clinic," "audiologist," or "consultant," in connection with promotion of products in a manner leading prospective buyers to believe that the device has professional approval . . . unless the medical connotation of these terms is accurately and truthfully presented; (3) Extravagant claims for the aids "invisibility" are barred.

Gift Toward Cancer Research To Memorialize Taft

Judge Alfred K. Nippert, formerly of the Hamilton County Court of Common Pleas, has announced a gift of $100,000 toward the creation of a special cancer research laboratory in memory of the late Senator Robert A. Taft as part of the Christ Hospital Institute of Medical Research, Cincinnati.

Judge Nippert, for many years president and now board chairman of Christ Hospital, last year gave $400,000 toward erection of the new medical research building at Christ Hospital. Dr. Leon H. Schmidt is director of the Institute of Medical Research.

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Aviation Physiology Is Subject of Conference at Ohio State

A three-day International Conference on Aviation Physiology at Ohio State University emphasized the growing attention centered on this subject at the University.

The conference was held September 7-9 and was one phase of the development of facilities for aviation medicine at O. S. U. Support for the establishment of such a facility has been given by the Aero Medical Association and by the Civil Aeronautics Administration which has recently transferred its medical research laboratory to Ohio State.

Included on the program were visiting authorities in aviation medicine from Switzerland, Sweden, Germany, the Netherlands, as well as from other universities and military establishments of this country.

During the past summer quarter a course on the graduate level in aviation physiology was offered at the University. Visiting lecturers included Dr. E. H. Christensen, professor of physiology, State College of Physical Training, Stockholm, Sweden; Dr. Robert T. Clark and Dr. Ulrich C. Luft of the School of Aviation Medicine, Randolph Field, Texas; Dr. C. F. Gell, U. S. Naval Air Development Center, Johnsville, Pa.; Dr. Barry King, Civil Aeronautics Administration; and Drs. James Henry and Otto Gauer of Wright-Patterson Air Force Base.

It is planned to expand both the teaching and research program in the field of aviation medicine in the near future, and it is anticipated that residencies will be available in this field within the current academic year.

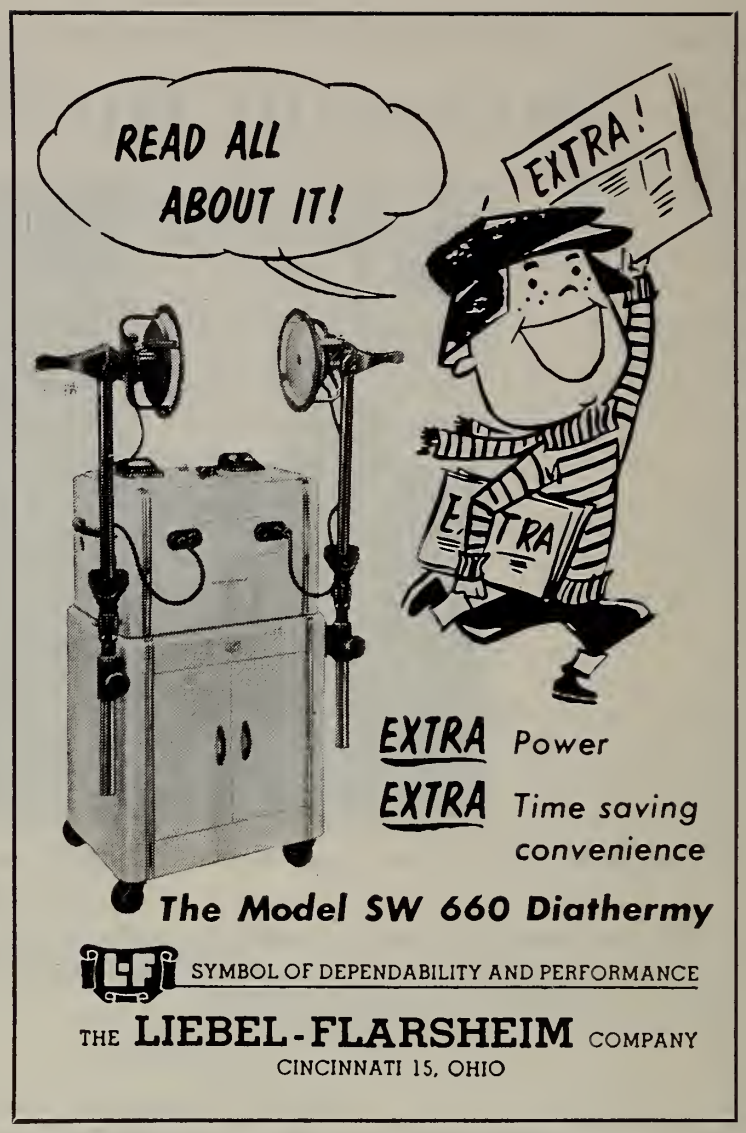
Dr. Richard L. Meiling, associate dean of the College of Medicine, opened the conference, which was arranged by Dr. Fred A. Hitchcock, of the Department of Physiology.

Nurses' Association Publishes History Of Nursing in Ohio

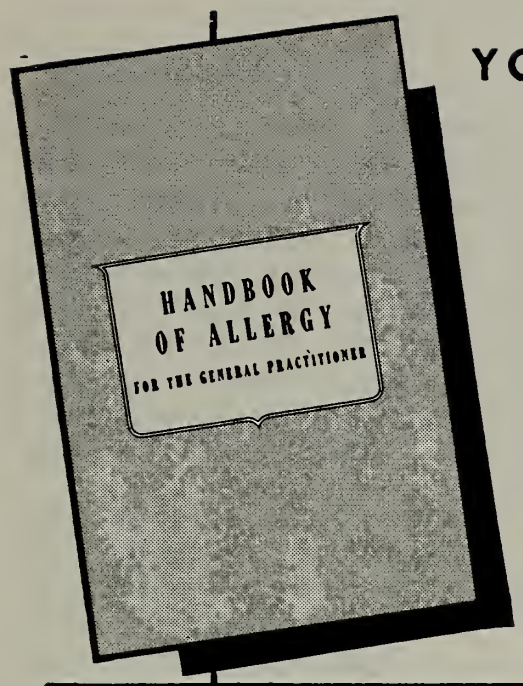
Nursing in Ohio tells a story of commanding interest to every hospital superintendent, physician and professional nurse. Starting with pioneer days and Ohio tales of the primitive nursing practices of those times, the story then moves into the 19th century.

Authors of the history are James H. Rodabaugh, Ph. D., and Mary Jane Rodabaugh, a husband and wife team. Dr. Rodabaugh heads the Department of Historical Research and Publications of the Ohio State Archaeological and Historical Society, Columbus, while Mrs. Rodabaugh is associated with the Ohio State Nurses' Association as managing editor of the *Ohio Nurses Review*.

Copies may be ordered from the Ohio State Nurses' Association, 904 E. Broad St., Columbus 5, at $4.00, plus 3 per cent sales tax in Ohio.







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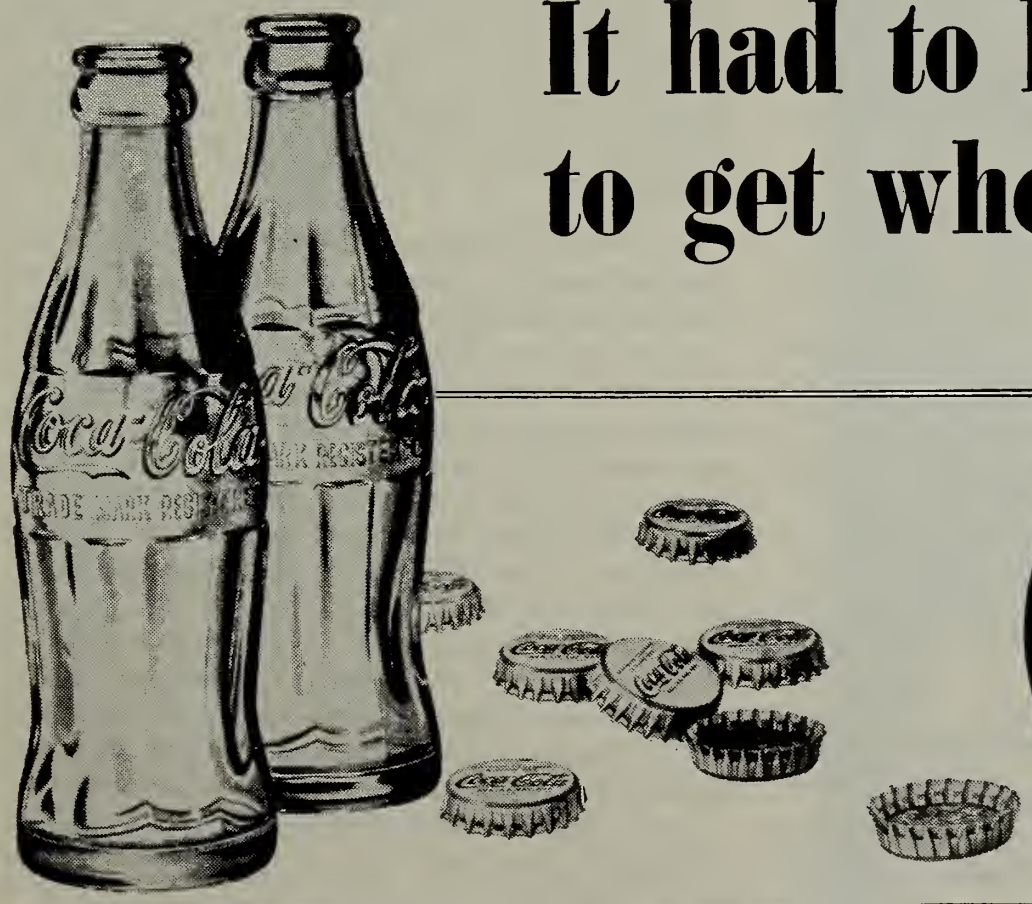
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In Memoriam . . .

Glenn R. Black, M. D., Akron; Hahnemann Medical College, 1949; aged 31; died August 31 in a drowning accident; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Black had completed his internship at City Hospital, Akron, and had practiced there since. His widow survives.

Myer Brody, M. D., Cleveland; Jefferson Medical College of Philadelphia, 1904; aged 70; died September 5; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Brody practiced for a few years in Philadelphia before moving to Cleveland in 1907. He had practiced there since with the exception of time for postgraduate study in Europe. He was a member of the Temple. Surviving are three daughters and two sisters.

William O. Eaton, M. D., Proctorville; Medical College of Ohio, Cincinnati, 1894; aged 83; died August 18. A native of the Proctorville area, Dr. Eaton had returned there upon his retirement several years ago. His practice for more than 40 years was in Ashland, Ky. Surviving are his widow, two sons and two sisters.

Floyd E. Ginder, M. D., Columbus; Starling Medical College, Columbus, 1904; aged 71; died August 18; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Ginder began his practice in Darbyville and moved to Columbus in 1927. Affiliations included memberships in the Masonic Lodge, Alpha Kappa Kappa, the Glen Echo and North Side Business Men's Associations and the Methodist Church. His widow and a daughter survive.

Walter C. Hill, M. D., Cleveland Heights; Western Reserve University School of Medicine, 1903; aged 77; died September 6; member of the Ohio State Medical Association; former member of the American Medical Association; diplomate of the American Board of Radiology; member of the American Roentgen Ray Society and the Radiological Society of North America. During virtually all of his practice in Cleveland, Dr. Hill was associated with the x-ray laboratory of Hill & Thomas, founded in 1905. During World War I, he went to France with the Lakeside Unit, and later served in military hospitals in Britain. Affiliations included Alpha Omega Alpha, Nu Omega Nu, the Union, Chagrin Valley Hunt and Kirtland Clubs and the Pepper Pike Country Club. His widow, a brother and a sister survive.

Paul M. Kaufman, M. D., Youngstown; Rush Medical College, University of Chicago, 1924; aged 55; died August 23; member of the Ohio State Medical Association; member of the American Medical Association; Fellow of the American College of Surgeons. Dr. Kaufman served all of his professional career in the Youngstown vicinity with the exception of time served during World War II overseas. Affiliations included memberships in the American Legion, several Masonic bodies, the Jewish War Veterans, Sigma Psi, the Jewish Community Center, the Squaw Creek Country Club and the Temple. Survivors include a son, a sister and two brothers, one of whom is Dr. Herman B. Kaufman of Zanesville.

Benjamin B. Kimmel, M. D., Cleveland-Pulte Medical College, 1898; aged 83; died August 15; former member of the Ohio State Medical Association; Fellow of the American College of Surgeons; member of the Board of Directors of the Academy of Medicine of Cleveland, 1943-1944. Dr. Kimmel served all of his professional career in Cleveland, with time out for service in World War I, and was a past president of the Cleveland Homeopathic Medical Society, the Ohio State Homeopathic Medical Society and the American Institute of Homeopathy. He was a member of Alpha Tau Omega. His widow and a stepson survive.

Raymond Marr, M. D., Cincinnati; University of Cincinnati College of Medicine, 1938; aged 48; died May 12; member of the Ohio State Medical Association; member of the American Medical Association; member of the American Association of Industrial Physicians and Surgeons. Dr. Marr served all of his professional career in Cincinnati. In addition to medical organizations, he was a 25-year member of the Masonic Lodge and a member of the Cincinnati and National Rose Societies. Survivors include his widow and two daughters.

Dan Moore McDonald, M. D., Akron; Starling Medical College, Columbus, 1902; aged 78; died August 5; member of the Ohio State Medical Association and the American Medical Association. Dr. McDonald had been a practicing physician in Akron from 1903 until his recent retirement, and had for 40 years been medical director of the Firestone Tire & Rubber Company. He was a recipient of the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. McDonald was a 50-year member of the Masonic Lodge and was affiliated with several Masonic bodies. He also was a trustee in the Presbyterian Church. Other affiliations included the Portage Country Club, the Akron Art Institute, the Wellsville Historical Society, Sigma Chi and Alpha Kappa Kappa. Survivors include a daughter and a son, Dr. Frank M. McDonald, also of Akron.

Neville H. McNerney, M. D., Cleveland; Cleveland-Pulte Medical College, 1913; aged 64; died

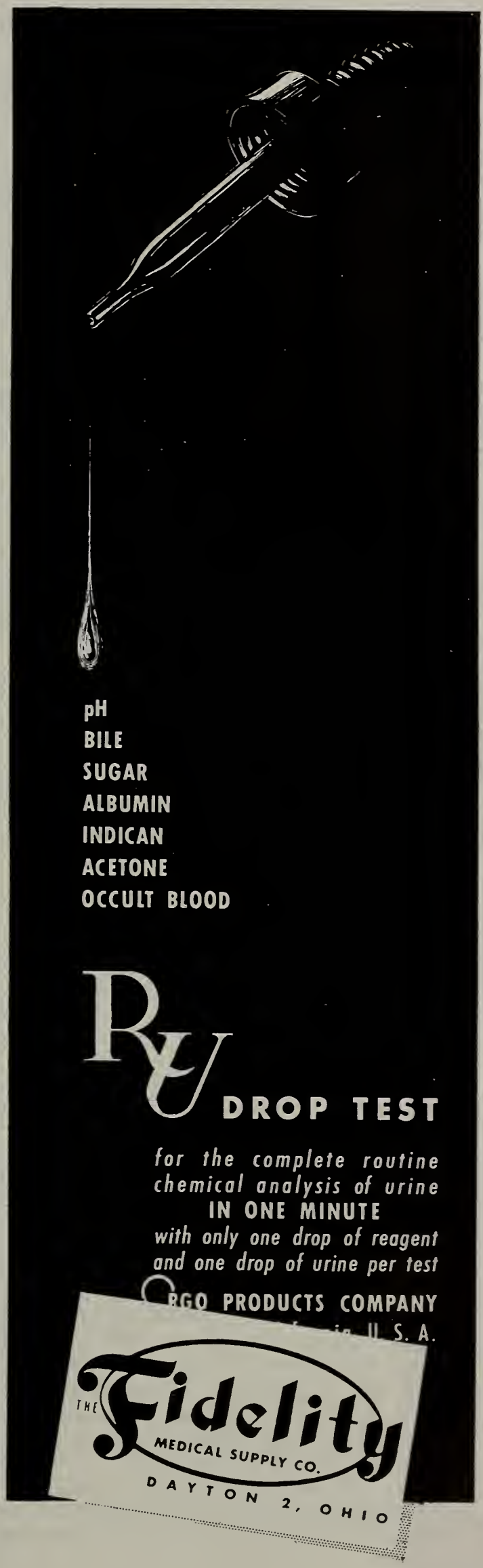
August 16; member of the Ohio State Medical Association and the American Medical Association through 1951. After serving with the Medical Corps during World War I, Dr. McNerney moved to Cleveland, where, in addition to private practice, he was surgeon for the Nickel Plate Railroad. He entered the service again in 1940 with the 37th Division; later attained the rank of colonel and headed Army hospitals in England. He returned to private practice in Cleveland after serving as medical director of the Veterans Administration Regional Branch with headquarters in Columbus. Affiliations included the Elks Lodge, American Legion, Veterans of Foreign Wars, the Masonic Lodge and the Methodist Church. Surviving are his widow, two daughters, a son and a brother, Dr. Joseph J. McNerney, also of Cleveland.

James J. Mills, M. D., Cincinnati University of Cincinnati College of Medicine, 1936; aged 43; died August 3; member of the Ohio State Medical Association. Dr. Mills entered service with the Army following graduation from medical college. The late General Patton awarded him the Distinguished Service Cross for heroism beyond the call of duty while serving in the European campaign. He also was awarded the Bronze Star and the Belgian Croix De Guerre. He was a member of the Veterans of Foreign Wars and the Disabled American Veterans. Surviving are his widow and a son.

Thomas A. Minahan, Sr., M. D., Niles; Cleveland-Pulte Medical College, 1898; aged 91; died September 6. Dr. Minahan moved his practice from Carnegie, Pa., to Niles in 1918 and continued in practice until a few years ago when he retired. He was a member of the Ohio and National homeopathic associations, and a member of the Catholic Church. Survivors include four daughters and three sons, one of whom is Dr. Thomas A. Minahan, Jr., of Hubbard.

Thomas Kenny Moore, M. D., Sharon Center; Jefferson College of Philadelphia, 1899; aged 80; died August 8; former member of the Ohio State Medical Association, last in 1939; president of the Summit County Medical Society in 1915. After practicing for a time in Detroit, Dr. Moore moved to Akron where he maintained an office until 1948 when he moved his office to Sharon Center. Only recently he was elected president of the International Hahnemann Association of Homeopathic Physicians. He belonged to the Rotary Club, Portage Country Club, University and Akron City Clubs, several Masonic bodies and the United World Federalists. Survivors include a daughter and two sons, one of whom is Dr. T. Scott Moore of Niles, Mich.

Emerson A. North, M. D., Daytona Beach, Fla.; Medical College of Cincinnati, 1906; aged 73; died August 21; member of the Ohio State Medical Association; member of the American Psychiatric



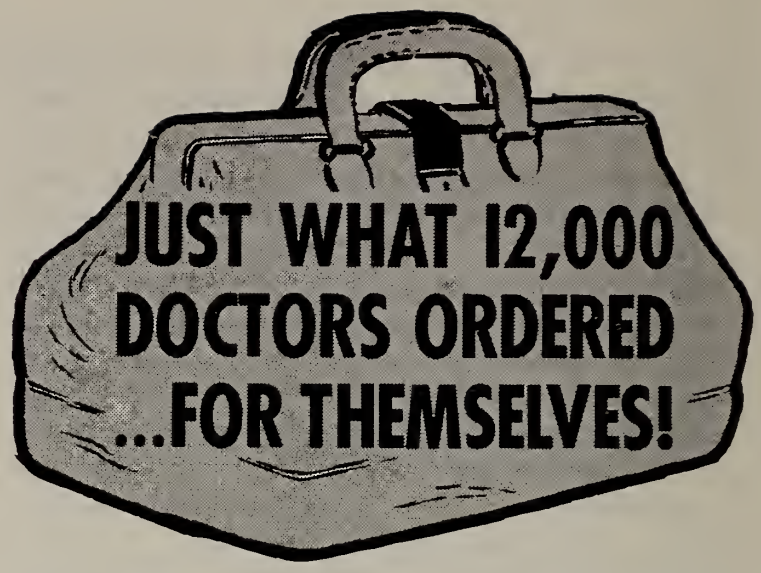
Association and the Central Neuropsychiatric Association. Dr. North had been residing in Florida after serving most of his professional career in Cincinnati. From 1917 to 1923 he was superintendent of Longview State Hospital, Cincinnati. From that year until 1940, he served as director of the national hygiene clinic of the Community Chest and during much of the same period was director of the University of Cincinnati's Department of Psychiatry. Fraternal and civic activities included memberships in the Rotary Club and the Masonic Lodge. Surviving are his widow, a daughter, a sister and a brother.

Harry S. Shamansky, M. D., Columbus; Ohio State University College of Medicine, 1917; aged 58; died May 16; member of the Ohio State Medical Association; member of the American Medical Association. A retired Army Medical Corps officer, Dr. Shamansky held the rank of lieutenant colonel. Service since the War had been with the Veterans Administration, and for several years he had been stationed in Washington, D. C. He returned to Columbus early in 1953. Survivors include two sons, three sisters and two brothers, Julian Shamansky, M. D., and Isaac Shamansky, D. D. S., both of Mt. Vernon.

Gordon Stone, M. D., Cleveland; University of Maryland School of Medicine, 1921; aged 55; died August 15; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Stone had been a practicing physician in Cleveland since the middle 1920's, and for years was associated with the Industrial Surgical Clinic. Surviving are his widow, a daughter and a sister.

Robert E. Suer, M. D., Wilmington; Indiana University School of Medicine, 1948; aged 28; died August 13; member of the Ohio State Medical Association; member of the American Medical Association; secretary-treasurer of the Clinton County Medical Society at the time of death, and member of two County Society committees. A veteran of World War II, Dr. Suer completed his internship at the Naval Hospital, Long Beach, Calif., and started practice in Wilmington in 1949. He was appointed last fall to fill out the unexpired term of coroner and elected as coroner in November. He was a member of the Presbyterian Church, the Masonic Lodge, Lions Club and the Snow Hill Country Club. Surviving are his widow, six children, two brothers and a sister.

Harry N. Ward, M. D., Hamilton; University of Cincinnati College of Medicine, 1925; aged 52; died August 22; member of the Ohio State Medical Association; member of the American Medical Association; past-president of the Butler County Medical Society and active on several Society committees. Dr. Ward had been a practicing physician in Hamilton for 27 years. In addition to his professional work, he was a member of several Masonic bodies and the Elks Lodge. Sur-

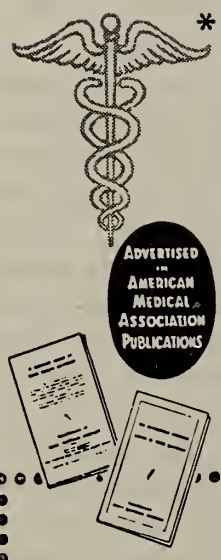




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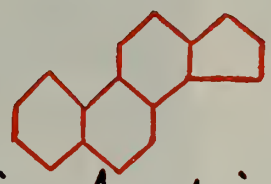


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viving are his widow, two sons, his father and two sisters.

John M. Wilcox, III, Cleveland; Western Reserve University College of Medicine, 1930; aged 46; died August 14. Dr. Wilcox returned to Cleveland early in 1953 after moving to Pittman, N. J., in 1947. He had previously been associated as medical director with the East Ohio Gas Company and the Socony-Vacuum Company. Earlier he had been with the E. R. Squibb Company working out of New York. During the war he was a flight surgeon. His widow and a son survive.

Spies V. Wilking, M. D., Los Angeles, Calif.; Starling Medical College, Columbus, 1898; aged 79; died August 10. Dr. Wilking practiced for a while in Ohio before leaving the State. Most of his practice was in Butte, Mont.

Perry W. Willey, M. D., Columbus; Starling Medical College, Columbus, 1897; aged 80; died August 13; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Willey practiced for 11 years at Lewis Center before moving to Columbus in 1908. He had been honored with the 50-Year Pin of the Ohio State Medical Association. In addition to his medical practice, he was associated with several Masonic bodies, the Loyal Order of Moose, the Elks Lodge, the Tri-Village Breakfast Club and the Methodist Church. Survivors include his widow, a brother and a sister.

Dangers from Vaporizer and Fumigator Devices

A warning against improper and excessive use of insecticide vaporizer and fumigator devices was issued in a recent report by the Committee on Pesticides of the American Medical Association.

The committee's report provided laboratory and clinical evidence of the risks attendant to improper use of these devices and the highly toxic material, usually lindane, that they dispense.

According to the committee's report, dispensing insecticides into the atmosphere of buildings and other enclosed spaces principally for the control of flying insects is being exploited in a variety of ways. Among the methods which have health hazards are those concerned with heating, igniting or otherwise evolving vapors or fumes of chlorinated hydrocarbon insecticides.

The report pointed out that reactions to lindane, such as irritation of the eyes, skin and respiratory tract, have been brought to the attention of the medical profession. In addition, some cases of such serious conditions as anemia, asthma-like afflictions, tracheitis, and near-fatal total suppression of urine secretion by the kidneys have been suspected of being caused by exposure to lindane from these devices.

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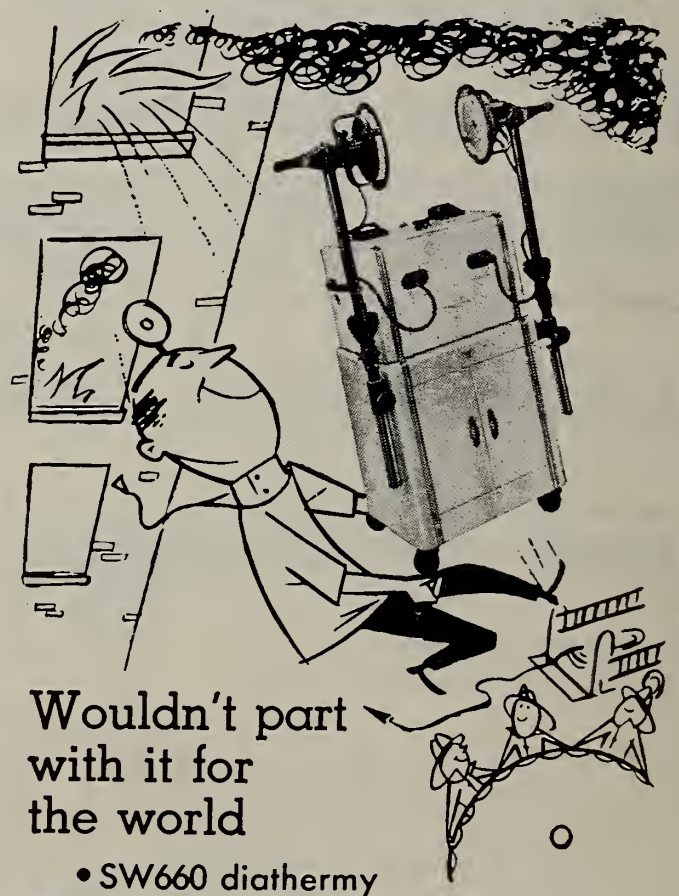


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Activities of County Societies . . .

CLINTON

Members of the Clinton County Medical Society voted to give complimentary medical examinations to members selected by each 4-H Club in the County in the "healthiest member" contest. It was recommended that the candidate's personal physician give the examination in each case.

Guest speaker for the August 5 meeting was Dr. William Mitchell, Columbus, who discussed "Contact Dermatitis and Hay Fever." Dr. Nathan Hale introduced the speaker.

MIAMI

Speaker for the September 4 meeting of the Miami County Medical Society was Dr. Herbert L. Brumbaugh, Dayton, who discussed problems of the feet. The meeting was held in the Nurses' Home of Stouder Memorial Hospital, Troy. Scheduled for October 1 was a joint meeting with the Western Dental Association.

New Members of the Society are Dr. Dale South, Troy, and Dr. Jerry Hammond, West Milton.

MONTGOMERY

A "paging number" system has been instituted among members of the Montgomery County Medical Society. When a doctor is paged at a public meeting, the number is used instead of the doctor's name. The paging number appears on the County Society's membership card.

TUSCARAWAS

A regular meeting of the Tuscarawas County Medical Society was held at the Boulevard Medical Building on July 9. The speaker of the evening was Dr. Joseph Stocker, of Sunny Acres Sanatorium, Cincinnati, who was introduced by Dr. W. E. Hudson. His discussion was on the subject of chest conditions and their x-ray diagnosis.

The question of immunizations given at the Well-Child Clinics was discussed. The County Society had previously approved the program of the Well-Child Clinics as submitted by the health commissioner. It subsequently went on record as recommending that immunization may be undertaken by the County Health officer only after the child has entered school. The Society ruled that by inference this would imply that there should or would be no immunizations given at the Well-Child Clinics.

Dr. Rinderknecht outlined tentative plans to observe Diabetes Detection Week in November.

For the August 13 meeting, a symposium on poliomyelitis was arranged by a committee consisting of Dr. Calhoon, chairman and Drs. Davis, Hamilton, Hostetler and Roche. The committee arranged for two nationally-known physicians

Cook County Graduate School of Medicine

POSTGRADUATE COURSES—1953

SURGERY—Intensive Course in Surgical Technic, two weeks, starting Oct. 12, Oct. 26, Nov. 9. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting Oct. 26. Surgical Anatomy & Clinical Surgery, two weeks, starting Nov. 9. Gallbladder Surgery, ten hours, starting Oct. 26. General Surgery, two weeks, starting Oct. 12. Surgery of Colon & Rectum, one week, starting Oct. 26. Thoracic Surgery, one week, starting Oct. 12. Esophageal Surgery, one week, starting Oct. 19. Breast & Thyroid Surgery, one week, starting Oct. 26. Fractures & Traumatic Surgery, two weeks, starting Oct. 26.

GYNECOLOGY—Intensive Course, two weeks, starting Oct. 19. Vaginal Approach to Pelvic Surgery, one week, starting Nov. 2.

OBSTETRICS—Intensive Course, two weeks, starting Nov. 2.

MEDICINE—Electrocardiography & Heart Disease, two weeks, starting Oct. 12. Gastroenterology, two weeks, starting Oct. 26. Gastroscopy, two weeks, starting Nov. 2.

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to conduct the symposium—Dr. Charles Terry, regional medical consultant of the National Foundation for Infantile Paralysis, and Dr. John F. Marchand, medical director of the Regional Respiratory Center, Louisville, Ky. Nurses and others interested in the subject as well as doctors from surrounding counties were guests. The local office of the Polio Foundation helped with the program.

Dr. R. D. Hildebrand, county health commissioner, spoke on policies of the Health Department in regard to gamma globulin distribution.

Activities of Woman's Auxiliary . . .

By MRS. EDWARD L. VOKE, Chairman, Publicity Committee, 243 Hampshire Road, Akron 13, Ohio

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LUCAS

Mrs. Myron Means was hostess to members of the nurse recruitment committee of the Auxiliary on July 28 at a luncheon in the Sylvanian Country Club.

Members of the Women's Auxiliary to the Academy of Medicine of Toledo and Lucas County met every day from 10 a. m. to 4 p. m. during the last week in August to make bandages for demonstration purposes for Civil Defense. Mrs. Howard Parkhurst and her telephone committee contacted the entire membership. Mrs. Roscoe H. Snyder, chairman of the Auxiliary Civil Defense Committee, was in charge of the project and had the following members on her committee: Mesdames Howard Parkhurst, Henry Bernstein, Boni Petcoff, Fred M. Douglass, Sr. The medical field service of Toledo Civil Defense solicited old white sheets and white shirts used in making the bandages. The dressings made were to be used in training work for medical field teams.

During August the Auxiliary sponsored a group of various health agency exhibits in the Agriculture Building at the Lucas County Fair.

The chairman for the health exhibits was Mrs. A. W. Hemphill, with Mrs. Herbert C. Weller, co-chairman. The hostesses for the week were Mesdames John Buck, L. H. Hauman, Lyle W. Kahler, Leopold Siberd, F. R. Canelli, and Robert Slotterbeck for Tuesday; Mesdames James Mullen, James McAuley, Henry Brunsting, Slotterbeck, and Henry Drake for Wednesday; Mesdames Herman S. Dunham, Martin Lorenzen, John Hillabrand, A. S. Avery, K. C. McCarthy, and Leopold Siberd for Thursday; Mesdames Fred M. Douglass, Sr., David M. Katcha, M. M. Thompson, Charles Boyer, and A. E. Canfield for Friday; Mesdames A. Paul Hancuff, J. B. Hersch, Harold Shapiro, W. W. Green, and Thomas Miller for Saturday; Mesdames Herbert C. Weller, A. W. Hemphill, and Boni Petcoff for Sunday.

Plans were made by the Social Committee at a luncheon meeting at the home of the chairman, Mrs. William M. Mewborn. Mrs. David Katchka is her co-chairman. Others on the committee include Mesdames O. H. Stone. William Preston, Stanley Andrews, jr., Samuel Zuker, M. M. Thompson, jr., W. Leroy Bryant, Richard Marker, W. A. Baird, David T. Curtis, F. V. Gipson, John E. Gallagher, Henry D. Brown, Elmer Haynes, Harvey C. Gunderson, and Franklin Earnest. Others attending were Mrs. C. J. A. Paule and Mrs. Norman B. Muhme, program chairman, Mrs. Edward L. Burnes and Mrs. Hazen L. Hauman, membership chairmen, and Mrs. Boni Petcoff, Auxiliary President.

Mrs. R. P. Whitehead, Jr., chairman of the study groups, entertained her committee for

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luncheon at the Hillcrest Hotel. Mrs. E. J. Singer, immediate past chairman of this committee, and Mrs. Petcoff, the president, attended with the committee members. They were Mesdames Paul Hohly, Max Schnitker, J. W. Millis, John Buck, M. R. McCarvey, Henry L. Hartman, and W. A. Phillips.

Mrs. Fred M. Douglass, chairman of the public relations committee, entertained the members of her committee at a picnic luncheon at the home of Mrs. Charles A. Bayer. Guests included Mrs. George H. Lemon, co-chairman and committee members, Mrs. J. R. McAuley and Mrs. Harry Scott. Heads of related committees who attended were Mrs. Henry L. Hartman, family life education; Mrs. R. H. Snyder, civil defense; Mrs. A. J. Kuehn, citizens day care for children; and Mrs. W. Leroy Bryant, radio and visual education, Mrs. Petcoff was also a guest.

Early in September, the members of the fund raising committee met for luncheon at the home of Mrs. Harold Shapiro. Mrs. J. B. Hirsch is co-chairman. Through funds raised in recent years, the group equipped the kitchen in the new Academy of Medicine Building. Other members of the committee are Mesdames: F. R. Canelli, Henry Cook, Fred M. Douglass, Jr., Henry Drake, John W. Erkert, F. F. Gipson, E. F. Glow, E. M. Gottschalk, Walter Greenson, Ned B. Hein, William G. Henry, Leo Janis, A. Rees Klopfenstein, David Levin, K. C. McCarthy, Howard Murphy, Charles Phillips, O. H. Stone, Gordon Todd, Herbert C. Weller, Ralph Wichter, and Andrew A. Winter.

SUMMIT

The Revolving Loan Fund for students in training at local hospitals was increased by a "Hat Parade" given by the Auxiliary. The fund raising party took place in the garden at the home of Mrs. Hubert Senné. More than 400 women attended.

Members of the Auxiliary who modeled the hats were Mesdames: M. Charles Morgan, Carl E. Krill, Uffe T. Jensen, George H. Mansfield, Harry W. O'Dell, and Joseph M. Ulrich, plus Mrs. Walter Rechsteiner, Mrs. James Pollock, Mrs. Robert Yeakley, and Mrs. Robert Ferris.

Mrs. R. G. McCready was general chairman of the party which featured an afternoon of bridge and canasta. Mrs. McCready and her co-chairman, Mrs. E. F. Hurteau, were assisted by Mesdames Robert E. Williams, Arnold V. Gold, Carl Korsmo, Walter Hoyt, jr., Roscoe Breneman, Robert DeWitt, James Pollock, Paul Cheek, Lewis Walker, Chester P. Widmeyer, Walter E. Brown, and Edward Kissel.

Mrs. Norman Wentsler, the president, Mrs. Frank T. Moore, and Miss Betty Schlitt from the local Madisons Store, arranged the "Hat Parade." Mrs. C. A. Raymond assisted the models.

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Accident Fatalities of Drivers And Passengers Mount

Nearly all of the steady increase in automobile deaths in the United States since 1949 is due to accidents involving drivers and passengers, rather than to those in which pedestrians were fatally injured, Metropolitan Life Insurance Company statisticians report.

In the group studied the death rate from accidents in which motor vehicles overturned on the road, ran off the roadway, or hit a curb, pole, or other fixed object increased by more than 40 per cent from 1949 to 1952. Similarly, the death rate from accidents involving a collision of two or more motor vehicles was up 26 per cent.

By contrast, the loss of life among pedestrians injured in automobile accidents was only slightly higher in 1952 than in 1949.

Although every age group under 65 years contributed to the over-all rise in the motor vehicle death rate, the largest increase occurred in the age range from 15 to 29 years, where more than 90 per cent of the deaths occur among drivers and passengers.

In this age range, the rise in the death rate between 1949 and 1952 averaged about 40 per cent.

In noting that the death toll from motor vehicle accidents in the United States had mounted, year by year, from 32,000 in 1949 to approximately 38,000 last year, the statisticians observed that unless the rise is halted soon the total for 1953 may equal the all-time high of 40,000 fatalities recorded in 1941.

The Indiana State Medical Association meets at French Lick, Ind., October 19-21.

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[Contribution from the Research Laboratories of Parke, Davis and Co.]

THE ACTIVE PRINCIPLES OF THE POSTERIOR LOBE OF THE PITUITARY GLAND.[1] I. THE DEMONSTRATION OF THE PRESENCE OF TWO ACTIVE PRINCIPLES. II. THE SEPARATION OF THE TWO PRINCIPLES AND THEIR CONCENTRATION IN THE FORM OF POTENT SOLID PREPARATIONS

By Oliver Kamm, T. B. Aldrich, I. W. Grote, L. W. Rowe and E. P. Bugbee

Received December 31, 1927 Published February 4, 1928

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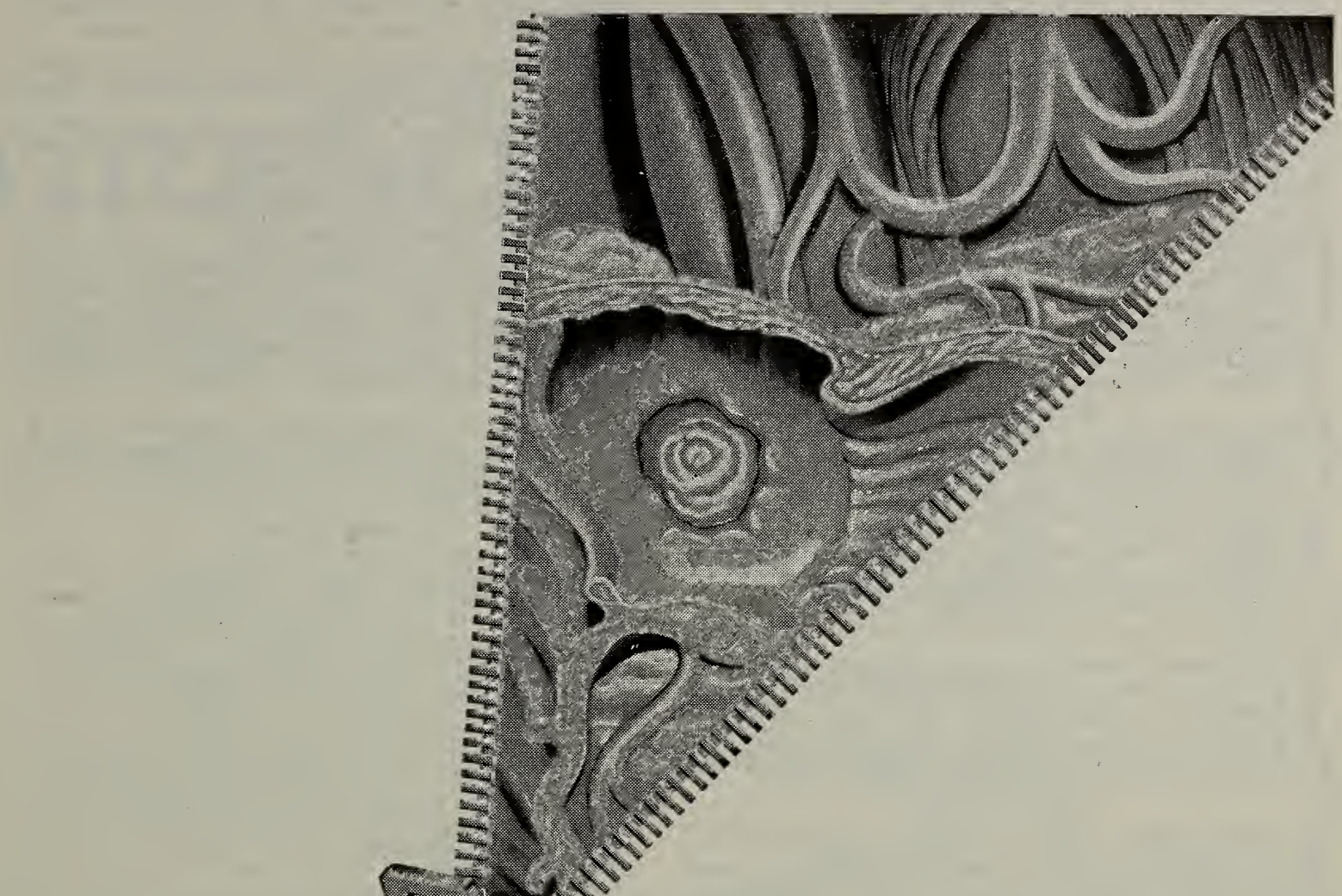
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The Physican's Bookshelf

By JONATHAN FORMAN, M. D.

The Diabetic Neuropathies, Publication No. 151, American Lecture Series, by Doctors Joseph I. Goodman, Siegfried Baumoel, Leonard Frankel, Louis J. Marcus, and Sigmund Wassermann, of Mt. Sinai Hospital, Cleveland, Ohio, (\$4.75. *Charles C. Thomas Company, Springfield, Ill.)* is a handy monograph on the well recognized complications of diabetes in which we get the viewpoints of an internist, a neurologist, a peripheral vascular disease man, and a cardiologist. All this is based upon 261 cases under observation.

Diabetes and Pregnancy, by Ralph A. Reis, M. D., Edwin J. DeCosta, M. D., and M. David Allweiss, M. D., (\$2.50. *C. C. Thomas, Springfield, Ill.)*, presents one problem of increasing importance because insulin has produced more cases. On the other hand, the advent of insulin has presented the juvenile diabetic with increased years, premature vascular changes with resultant cardiovascular damage. Here we have the help of the thinking at Michael Reese Hospital in Chicago.

Good Food for Diabetics, by Eleanor Record Sigel, (\$2.00. *Grosset & Dunlap, Inc., New York 10, N. Y.)*, is a specialty cook book containing medically approved diet information plus hundreds of delicious recipes and menus for diabetics and all of the family.

Doctor Dan, The Bandage Man; Dr. Squash, The Doll Doctor; and **Nurse Nancy**, Published by *Simon & Schuster, Inc., New York 20, N. Y.*, are three wonderful little books which the children who come to the physician's office are crazy about. They are a part of the Golden Library for children.

The Anatomy of The Nervous System—Its Development and Function, by Stephen Walter Ranson, M. D., and Sam Lillard Clark, M. D., (\$8.50. Ninth Edition. *W. B. Saunders Company, Philadelphia 5, Pa.)*, attempts to blend an account of structure with function in such a way as to give an understanding of how the nervous system is made up and how it works.

The Medical Annual 1952—70th year. Editors, Sir Henry Tidy, K. B. E., M. D., F. R. C. P.; and A. Rendle Short, M. D., F. R. C. P., B. S., (\$7.00. *J. B. Lippincott Company, Philadelphia, Pa.)*. Four hundred and fifty pages of abstracts of the most important articles of the year, thus making a year book of treatment and practitioners' index done in the best style of our English cousins.

Doctor in The House, by Richard Gordon, (\$2.75. *Harcourt, Brace and Company, New York 17, N. Y.)*. It is not often that we are able to find a doctor of medicine turned humorist. But a British physician (sic) tells of the life, loves, and labors of an English medical student on the rough and ribald road that leads to the august estate of M. D. It will recall your own earlier and funnier experiences.

Cherry Ames, Clinic Nurse, by Julie Campbell Tatham, (\$0.95. *Grosset & Dunlap, Inc., 1107 Broadway, New York 10, N. Y.)*. Many have followed Cherry from her student days through 14 books by two authors; have laughed over her pranks, thrilled over her gay adventures and wept with her over her problems. Here is another installment in this busy nurse's life.

The Riddle of Cancer, by Charles Oberling, M. D. Translated by William H. Woglom, M. D., (\$5.00. Revised Edition. *Yale University Press, New Haven 7, Conn.)*, being a series of Lectures delivered before the Cancer Institute of the Faculty of Medicine of Paris and the Faculty of Medicine of Theran in attempt to validate the various theories as to the cause of the condition. A competent review of all experimental work of importance to date. Much stress is put on virus as a cause.

Modern Science and Modern Man, by James B. Conant, (\$2.25. *Columbia Univ. Press, New York 27, N. Y.)*. Hampton Lecture Number 5. The President of Harvard tells how the philosophical implication of the newer discoveries in physics and chemistry are producing an intellectual revolution with great significance to the ambitions, hopes and fears of intelligent people.

Personality Development in Adolescent Girls, by Lawrence K. Frank, Ross Harrison, Elizabeth Hellersberg, Karen Machover and Meta Steiner, (\$4.50. *Society for Research in Child Development, Inc., School of Medicine Louisiana State University, New Orleans, La.)*, is a monograph in the series of child development presented at Yellow Springs, Ohio and concerns 300 girls whose emotional problems were more frequent and severe than was anticipated. There was a general fear of sex and of growing up. Much of the trouble came from adjusting to a program designed to please the most significant person in her family and to getting an acceptance from her age group.

What's Your Problem?, by Alfred Blazer, M. D., (\$3.50. *The Citadel Press, 222 Fourth Avenue, New York 3, N. Y.)*. A psychiatrist with experience in clinics and private practice, and in addition that gained from conducting a column, answers over one hundred questions dealing with

love, marriage, sex, personality, psychosomatic symptoms, fear, frustration, and other emotional problems.

Treatment of Mental Disorders, by Leo Alexander, M. D., ($10.00. *W. B. Saunders Co., Philadelphia 5, Pa.)*, written for the medical student, the physician, and especially the young neuropsychiatrist. The emphasis is on the practical.

Clinical Obstetrics, edited by Clifford B. Lull, M. D., and Robert R. Kimbrough, M. D., ($10.00. *J. B. Lippincott Co., Philadelphia, Pa.)*. The volume records the current methods of management of the pregnant woman in the Division of Obstetrics and Gynecology of the Pennsylvania Hospital and reflects the treatment of 20 key people each contributing special knowledge and experience. The selection of reference, illustration and text has been discriminating rather than exhaustive. The approach has been to the bedside and contact with the patient.

Helping Your Heart, by Emanuel Goldberger, M. D., ($3.75. *Longmans, Green and Company, New York 3, N. Y.)*, is designed to take the fear out of heart disease. It gives authoritative information for the intelligent patient—a book of help and hope.

Child Development, by William E. Martin and Celia Burns Stendler, ($6.50. *Harcourt, Brace & Company, 383 Madison Avenue, New York 17, N. Y.)*, describes the process of growing up in society so that parents may understand their children better, as well as the factors inside the home that influence the development of these youngsters.

Endocrine Treatment in General Practice, edited by Max A. Goldzieher, M. D., and Joseph W. Goldzieher, M. D., ($8.00. *Springer Publishing Company, Inc., New York 10, N. Y.)*. The concentrated efforts of investigation in the field of endocrine biochemistry and physiology have produced a wealth of new information and a whole new set of therapeutic agents which a corps of experts under competent editorship have assembled here for the rest of us. An unusual feature of this book is the **Diet Prescription** booklet which is inserted as a supplement to Dr. George Anderson's chapter on Carbohydrate and Fat Metabolism which will prove helpful and easy for any diet that restricts calories. This may be purchased separately and in quantities for office use.

Headaches: Their Nature and Treatment, by Stewart Wolf, M. D., and Harold G. Wolff, M. D., ($2.50. *Little, Brown & Company, Boston 6, Mass.)*. These two widely known neurologists sum up in popular terms what is known today about the most common of symptoms and what can be done about them. This is not a book of home remedies but rather a clear explanation of the various problems presented.

Hypertension: A Manual for Patients, by Irvine H. Page, M. D., ($3.00. Sixth Edition. *C. C. Thomas Co., Springfield, Ill.)*. This volume has been designed as the first prescription for patients with high blood pressure. In the last ten years thousands of patients have been helped because their personal physician gave them this book to read with its text resting firmly on the known facts about the underlying pathologic physiology.

Clinical Allergy, by French K. Hansel, M. D., ($17.50. *The C. V. Mosby Company, St. Louis, Mo.)*, presents a complete text on the subject of general allergy replacing the author's previous text on **Allergy of The Nose and Parasinuses** published in 1936. It is a must of every allergist, dermatologist, ear, eye, nose and throat specialist. It should be in every medical library especially intern libraries.

The 1952 Year Book of Dermatology and Syphilology, edited by Marion B. Sulzeberger, M. D., and Rudolf L. Baer, M. D., ($6.00. *Year Book Publishers, Inc., Chicago 11, Ill.)*, maintains its usual high standard in abstracts and comment on the year's literature in the field. As always, it has an opening chapter devoted to a practical lecture on some common skin condition which we all see frequently and are often baffled by. The subject this year is especially timely, i. e., "Present Status of ACTH, Cortisone, and Compound F in Dermatologic Management: A Guide for the General Practitioner."

Conduction Anesthesia, by George P. Pitkin, M. D., edited by Drs. James L. Southworth, Robert A. Hingson, and Winifred M. Pitkin, ($22.50. Revised new Second Edition. *J. B. Lippincott Co., Philadelphia 5, Pa.)*. This is the most complete monograph on the subject. It covers the whole field of the new local anesthetics, the more efficient and controllable vasopressors, new preoperative analgesics, as well as the advances in our knowledge of neuro-anatomy and the mechanical advances in administration.

Synovial Fluid Changes in Joint Disease, by Marian W. Ropes, M. D., and Walter Bauer, M. D., ($4.00. A Commonwealth Fund Book, published by *Harvard University Press, Cambridge 38, Mass.)*. This is a definitive study of joint fluid in health and disease and therefore will afford a wide range of usefulness.

The Physician in Atomic Defense, by Thad P. Sears, M. D., ($6.00. *The Year Book Publishers, Chicago 11, Ill.)*. It is the deep-seated conviction on the part of Dr. Sears, the author, that the community should be prepared for atomic warfare. He has therefore put together in brief and readable form the pertinent essentials of the physics of the atom gathered from varied sources.



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JONATHAN FORMAN, M. D., *Editor*

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Diabetes Mellitus in the Aged

JOSEPH I. GOODMAN, M. D., and LEONARD B. GOLDBERG, M. D.

IT is generally believed that there is a basic difference between diabetes mellitus in the older age groups and that in younger persons. According to Joslin[1] patients who develop the disease after age 60 exhibit it in a mild form much like that of the fat diabetic between the ages of 40 and 60 although, as he points out, in many instances the patient manifests the more severe type of youth.

Moreover, it is stated that the older diabetic's condition is likely to remain stationary or he may even require less and less insulin as time goes on. In other words, they do not appear to demand as close supervision as do younger persons. Also, in Joslin's older patients the condition develops more insidiously so that the exact time of onset is not as readily ascertainable as in younger diabetics.

It is agreed that a considerable proportion of older diabetics require no insulin and become aglycosuric on diet alone. Further, it is assumed that those who require insulin are the so-called stable type of diabetic who would do well on any kind of insulin and that the majority are on small or moderate doses (under 40 units). Still, Wauchope[2] reported three patients aged 78, 64, and 65 years who were taking over 100 units of insulin daily, i. e., 120, 156, and 120 units respectively. Certainly, everyone admits that the older diabetic should be treated with extreme caution to avoid vascular accidents.

FIFTY-NINE CASES REVIEWED

In order to ascertain whether diabetes in the aged is actually distinctive and, if so, to define these characteristics more clearly, 59 consecutive case records of diabetic patients in whom diabetes was first discovered after the age of 60 were reviewed. Thirty-three cases were from the private service, 14 from chronic disease hospitals and 12 from a local Veterans Administration (Crile) Hospital. There were 36 male patients and 23 females. However, in the private series, which was a much more random selection, there were 17 men and 16 women.

Submitted August 14, 1953.

AGE AND INCIDENCE

The age distribution at the onset of the diabetes is shown in Table I. In our series 50 per cent of the cases had their onset of diabetes before 65 years, and 70 per cent before the age of 70. An independent analysis of 33 diabetics at

TABLE I
Age Distribution at Onset of Diabetes

Ages	Cases	Per Cent
60 - 64	31	52.5
65 - 69	12	20.3
70 - 74	9	15.3
75 - 79	4	6.9
80 - 84+	3	5.0
Total	59	100.0

The Authors

● Dr. Goodman, Cleveland, is senior clinician and clinician-in-charge, Diabetic Clinic, Mt. Sinai Hospital; associate physician, Highland View Hospital; assistant clinical professor, Western Reserve University.

● Dr. Goldberg, Cleveland, is medical director, Jewish Orthodox Home for the Aged; physician, Diabetic Clinic, Mt. Sinai Hospital; assistant visiting physician, Mt. Sinai Hospital; demonstrator in medicine, Western Reserve University School of Medicine.

two homes for the aged confirmed this figure. Statistics show that the peak age for the onset of diabetes, both males and females, is 50 to 54 years. In Joslin's data approximately 15.4 per cent of male and 22.5 per cent of female diabetics are above 60 years of age and exactly one-half of these are between 60 and 64 years of age.

The rarity of onset of diabetes above 65 years, and especially in the eighth and ninth decades, indicates that diabetes is not an old age disease. However, of a combined total of 318 residents in homes for the aged (average age 78 years) 33, or approximately 10 per cent, were diabetics. Since 12 persons of this group were above 80 years of age, obviously, the physician must be prepared to handle diabetes in all age groups.

Thirteen patients (22.2 per cent) had a family history of severe diabetes. This was true in nine out of the 23 women (39.1 per cent).

WEIGHT

An accurate history of the patient's weight was available in 48 cases. Forty-two patients had been at least 20 per cent overweight for many years. Only three patients had been at their ideal weight most of their lives. Three cases had been underweight. Comparisons of the ideal weight were made in 53 cases. Although many patients had lost weight prior to the onset of the diabetes, 40 were still significantly obese. Only two cases had an ideal weight, 11 were underweight, and some were actually classified as undernutrition.

One can conclude from this that there is a close association of obesity and diabetes in the aged also.

PATIENTS WITH SYMPTOMS OF DIABETES MELLITUS

The presence of definite clinical symptoms led to the investigation and a diagnosis of diabetes in 30 patients (Table II). In most of the patients multiple symptoms were present. Weight loss, thirst and polyuria were the chief complaints. Pruritis vulvae was present in 50 per cent of the women with symptoms.

Diabetes was associated in 24 cases without any of the classical symptoms. Usually these patients were brought to their physicians because of an associated illness (Table III). Minimal symptoms had been present in four of these patients, but they were not elicited until after the diagnosis was made because the patients did not consider them important. One patient was actually admitted in coma without knowledge of diabetes. Thus it appears that the old person does not complain of diabetic symptoms and frequently the onset is very insidious. Consequently, in this group, discovery of diabetes is dependent more on routine examinations, such as diabetes detection drives.

CLINICAL SIGNS IN OLDER PATIENTS WITH DIABETES—NEUROPATHY

Neurologic signs were present in 29 of the 59 cases studied. The most frequent sign was an absent or greatly diminished achilles tendon reflex. While diabetic neuropathy may occur at any time from childhood to very old age, most authors report the average age of patients with evidence of neuropathy to exceed 50 years and an increasing proportion in each succeeding decade. In our own studies[5] the average age of the patients with neuropathy actually paralleled that of diabetics as a whole, ranging from the extremes of 10 to 90 years, with an average age of 53.8 years.

Loss of vibratory sense is a very frequent sign in patients with any kind of neuropathy and is equally true in diabetic neuropathy. Unfortunately, there appears to be a progressive loss of vibratory acuity with advancing age so that, in testing patients over 60 years of age, it is virtually impossible to ascertain the significance of diminished vibratory sense. It would appear, therefore, that testing of the vibratory sense has limited diagnostic value in the older age groups.

In previous studies of patients with diabetic neuropathy[5] the achilles tendon reflexes were absent or greatly diminished in 48 per cent of the patients and the patellar reflexes in 25 per cent. In the present group of older diabetics

TABLE II

SYMPTOMS AND SIGNS AT ONSET OF DIABETES

Symptoms	Cases		Signs	Cases	
A. Symptomatic—Diabetes with Clinical Symptoms		30	A. Neurologic		29
1. Weight Loss	21		1. Absent Achilles	26	
2. Polydypsia	17		2. Absent Patellars	8	
3. Polyuria	16		3. Absent Biceps	3	
4. Weakness and/or Fatiguability	10		B. Retinopathy		13
5. Nocturia	8		C. Hepatomegaly		7
6. Neuritic Symptoms	7		D. Acetone		3
7. Polyphagia	5		E. Glycosuria		*
8. Pruritis Vulvae	5		F. Blood Sugar		*
B. Asymptomatic—Diabetes found by routine exam. for associated conditions		24	G. Glucose Tolerance		*
1. Completely Asymptomatic	19		* These signs do not lend themselves to entry into the table and therefore will be discussed in the text.		
2. Symptoms Elicited after Finding Diabetes	4				
3. Diabetes Found with Patient in Coma	1				
C. Undetermined	5				

the achilles reflexes were absent or greatly diminished in 26 of 59 patients (46 per cent) and the patellar in only 8 (14 per cent). Certainly, the effect of age on the tendon reflexes, if any, is not apparent here. This conforms to our former conclusions that the loss of tendon reflexes is an effect of diabetes *per se* on the extremely sensitive reflex fibers of the peripheral nerves.

Since elderly diabetics present evidence of neuropathy it is important to decide whether, as generally believed, old age *per se* has any effect on the tendon reflexes. Accordingly, we investigated this question in normal individuals with no possible cause to have any disturbance of the tendon reflexes in the lower extremities.[5] Table VI In 56 patients between 55 and 70 years of age the achilles reflexes were obtained in 53 (94.6 per cent). In 22 cases above 70 years of age 81.8 per cent still retained all the tendon reflexes in the lower extremities. It appears from this that, up to 70 years of age, at least, loss of the tendon reflex in the lower extremities has nothing to do with the patient's age. Therefore, it is extremely unlikely that the high incidence of achilles tendon areflexia in our patients can be attributed to aging. We believe this to be a specific effect of uncontrolled diabetes on the reflex fiber of the peripheral nerve.

Symptoms of an active peripheral neuropathy, namely, pain and paresthesia, was noted in seven patients in this series of aged diabetics. We consider these symptoms along with polydipsia, polyuria, etc., as part of uncontrolled diabetes and an indication of some disturbance of the intermediary metabolism. Other authors are inclined to attribute the neurologic manifestations of diabetes to changes in the vasa nervorum associated with generalized vascular disease. A discussion of the pathogenesis of diabetic neuropathy will be found elsewhere.[5] In short, we do not concur with the vascular theory and strongly adhere to the concept that neuropathy is closely interlocked with disturbances in intermediary metabolism.

EYE CHANGES

Barach classifies both retinopathy and cataracts as complications primarily of elderly diabetics, and found 13 cases of retinopathy and 39 of cataract in 317 diabetics past the age of 60. In our series of 59 patients with onset of diabetes after the age of 60 years, 13 patients had retinopathy. The series is too small to determine if this is significant. Many other authors, including ourselves, do not associate the lesions of diabetic retinopathy with old age, but rather accept it as a specific lesion of diabetes *per se* at any age.

HEPATOMEGALY

Hepatomegaly was found in seven patients. This was asymptomatic and believed to represent a fatty liver. With improvement of the diabetic state the enlarged livers returned to normal size.

GLYCOSURIA AND HYPERGLYCEMIA

Approximately 40 per cent of the patients had a mild glycosuria of less than 10 grams of sugar per 24 hours at the onset of their diabetes. Twenty-five per cent excreted 10 to 40 grams of glucose and 35 per cent of the patients excreted more than 40 grams in 24 hours.

Blood sugar determinations and glucose tolerance tests were done only in a few cases and usually were not necessary to establish the diagnosis of diabetes. There was nothing distinctive about the range of blood sugar values when compared to those of the younger diabetic groups.

Acetone was reported in only three patients. On the other hand, moderate to severe glycosuria was present in 60 per cent of the cases. Apparently there is less tendency for these elderly diabetics to go into acidosis. This is not to say that the physician can relax his efforts as acidosis is insidious in onset.

While diabetic coma occurs most typically in the young, it occurs in old age also but is always a serious complication with a high mortality rate. One of our patients presented, and another died in diabetic coma. There are no essential differences in the management of diabetic coma in the aged except to stress again the dangers of hypoglycemia and its possible effect on the vascular tree. While giving sufficient fluids one must be careful not to overload the system.

DIETS

The diets were prescribed on the basis of the patient's ideal weight. We employ the maximum longevity tables developed by the Metropolitan Life Insurance Company to determine the weight of the patient. These ideal weight charts are based upon the very important conclusions drawn from their studies that an adult individual who does not exceed the weight which he attains at age 25 is most likely to attain maximum longevity. In other words, a weight gain with increasing age is not conducive to longevity. The tables take into account the body build of the individual, being subdivided into small, medium and large frames.

Most of the patients were overweight and the reduction diet was prescribed most frequently. We employ a 1200 calorie diet for overweight patients, 2200 calories for maintenance, and 2600 calories for the underweight diabetic. These diet values are the standard diets prepared by the American Dietetic Association and the American Diabetes Association.

INSULIN

Barach found that only 15 per cent of 317 diabetics over 60 years of age require insulin as compared with 60 per cent of his young and middle-aged diabetics. It should be pointed out that

this author was careful not to seek normal blood sugar levels. Insulin is not to be used in the obese diabetic or in other older diabetics until an appropriate diet has been tried first. The use of insulin frequently becomes an easy substitute for diet. When this procedure is followed, obesity and hyperglycemia, which usually can be eliminated completely by diet, may actually necessitate an increased insulin dosage.

The cautious administration of insulin in older diabetics is advisable, not only to prevent shocks, but also to prevent excessive appetite which leads to obesity and further strain on the cardiovascular system and to avoid the possibility of coronary insufficiency secondary to insulin reactions.

Most of Barach's patients who took insulin used either protamine zinc insulin or PZI combined with crystalline insulin. In a recent study we found the "protamine insulins" (PZI, mixtures and NPH-50) to be the greatest offenders in causing insulin reactions, both as to frequency and severity, by comparison with regular insulin and globin. Consequently, we hesitate to employ the protamine insulins in patients over 40 years of age, but especially in those over 50 years of age.

In this study approximately one-half of the patients needed no insulin or at the most five or ten units. Only six patients required 40 to 50 units per day. The remaining patients required moderate doses, from 15 to 30 units. The amount of the original glycosuria gave no indication of the ultimate insulin requirement. Thus, a seemingly "mild" diabetic may require insulin to eliminate glycosuria. Conversely, one patient, who spilled 124 grams of glucose in 24 hours, became aglycosuric without insulin on a reduction diet and weight loss.

HYPOGLYCEMIA

On account of the high percentage of coronary atherosclerosis in the aged diabetic a warning of the importance of avoiding reactions cannot be overemphasized. Cases of sudden death, heart attacks and cerebrovascular accidents have been described in elderly diabetics who were too meticulous in their zeal to keep sugar free or who had hypoglycemic reactions for some other reason. Consequently, practically all authors concur in the belief that in the elderly diabetic the bars should be let down for safety's sake in favor of less strenuous physiologic control of the blood and urinary sugar. Therefore, physicians are satisfied to maintain blood sugar levels as high as 200 mgm. in such patients in preference to any insulin reactions.

In our experience elderly diabetics taking insulin get along satisfactorily if permitted to excrete from 0 to 10 grams of glucose in the 24 hour urine period. Six patients who were taking insulin in this study reported moderate to severe insulin reactions. It is not known for certain whether or not food had been omitted, but five of these six patients were taking protamine zinc insulin. After they were transferred to regular insulin, usually in smaller doses, these hypoglycemic episodes did not occur.

ASSOCIATED CONDITIONS

Every diabetic patient in this series had one or more associated chronic illnesses, some of which were significant (Table III). In many cases the control of diabetes was complicated by the concomitant condition. For example, an old man with impaired vision and a peptic ulcer encounters difficulty in consuming his diet accurately and in measuring insulin dosage accurately. This is well shown by the rapid control of institutionalized patients.

Physicians in all types of practice must be prepared to encounter diabetes in their older patients,

TABLE III

Associated Conditions in Aged Diabetic Patients

		Cases
1.	Atherosclerosis	57
	A. Proximal	51
	B. Peripheral	31
	(1) Amputations	6
	Male	5
	Female	1
	(2) Diabetic Ulcers	6
	C. Coronary	22
	Male	14
	Female	8
	(1) Infarcts (All Males)	4
	D. Cerebral	7
	(1) Strokes	6
	Male	5
	Female	1
2.	Ophthalmologic Conditions (Excluding Retinopathy)	21
	A. Cataract	16
	Male	10
	Female	6
	B. Corneal Arcus	10
3.	Prostatic Hypertrophy	12
4.	Chronic Infection	11
	A. Bronchitis	4
	B. Otitis Media	3
	C. Ischio-Rectal Abscess	2
	D. Gingivitis	1
	E. Conjunctivitis	1
	F. Vaginitis	1
5.	Hernia	10
	A. Inguinal	9
	B. Hiatus	2
6.	Varicose Veins	9
7.	Hypertrophic Arthritis	8
8.	Senile Emphysema	8
9.	Hypertension	7
10.	Kidney Diseases	4
11.	Carcinoma	4
	A. Rectum	1
	B. Bladder	1
	C. Cervix	1
	D. Intestine	1
12.	Alcoholism	3
13.	Peptic Ulcer	3
	A. Resected	1
14.	Edema	2
15.	Psychoneurosis	2
16.	Rectocele	2
17.	Cystocele	2
18.	Ecchymoses	2
19.	Parkinsonism	1
20.	Absent Testicle	1
21.	Kyphosis	1
22.	Colloid Goitre	1
23.	Herpes Zoster	1
24.	Cholecystectomy	1

and must understand the effects which diabetes has on the natural course of the associated disease.

ARTERIOSCLEROSIS

Vascular lesions are the most frequent lesions by far which we encountered, being present in 57 of the 59 cases. Until recently it was presumed that arteriosclerosis is a natural concomitant of aging and that an early onset of arteriosclerosis simply implies premature onset of senility. The fallacy of this concept is clearly apparent in diabetics in whom the onset of arteriosclerotic complications is so common at earlier ages. Moreover, Wilens, Gofman and others have shown conclusively that atherosclerosis, the most significant form of arteriosclerosis, is an acquired disease which is reversible.

CRITERIA OF ATHEROSCLEROSIS

In previous studies by ourselves and colleagues, the following criteria for the clinical detection of atherosclerosis in the living patient were established:

(1) the carotid-sinus-pressure test;
(2) palpation of the subclavian artery pulsations in the supraclavicular fossa;
(3) the presence of calcification in the aortic knob in a six-foot film of the chest;
(4) calcification the abdominal aorta in a lateral view of the lumbar spine and
(5) reduced blood flow in the lower extremities ascertained by clinical studies.

Tests 1, 2, and 3 are indicative of atherosclerosis in the thoracic aorta, the great vessels and their tributaries, principally the coronary and cerebral arteries. We term this general area "proximal atherosclerosis" in contrast to "peripheral atherosclerosis" involving mainly the lower extremities. The latter is diagnosed chiefly through criteria 4 and 5.

Using the above criteria of atherosclerosis we found an incidence of 88.7 per cent of proximal atherosclerosis in diabetics of all ages.[3, 4] In the present group of patients over 60 years of age the incidence of clinically detectable atherosclerosis was 96 per cent, 57 out of 59 patients tested. Moreover, this study of older diabetics, using ordinary physical examination and electrocardiography, coronary atherosclerosis was diagnosed in 22 of 59 cases, 14 of whom were males and 8 females. Four patients had myocardial infarctions (all males). From these figures it is evident that, though coronary sclerosis has a high incidence in nondiabetic aged persons, it is much more common in aged diabetics, again showing the effects of a process other than aging. Seven patients in our series showed evidence of cerebral atherosclerosis; of these, six had cerebrovascular accidents and all but one were males.

Impaired circulation in the lower extremities, a strong indication of peripheral atherosclerosis, was diagnosed in 31 of the 59 diabetic patients in this series, an incidence of 52 per cent as compared to 46 per cent in our previous study of diabetics of all ages. Hence, while reduced blood flow in the lower extremities is quite common to the older diabetic, it is also common in the younger age groups. Six patients of this group had diabetic ulcers.

Patients with amputations are not frequent among the older patients in this study. There were six such patients, one a bilateral amputee, and of these five were male and only one female. We believe the incidence of gangrene can be reduced substantially by meticulous foot care, thorough instruction and regular visits to a competent, well indoctrinated chiropodist.

CARE OF THE FEET

One of the troublesome manifestations of ischemia in these patients with peripheral atherosclerosis is long, thickened toenails frequently closely adherent to the nailbed. In such patients the feet require very skillful handling by a chiropodist. The patients must be cautioned against cutting their own toenails and corns since many of them have poor eyesight and very unsteady hands. The feet should be kept clean by daily washing and dried thoroughly. Tinea infection should be sought and eliminated promptly avoiding strong irritating local preparations such as salicylic acid or iodine. Desenex® powder or other medicated foot powders are usually satisfactory. Circular constricting garters are contraindicated in all older patients and preferably thick, woolen socks without holes and thick crepe sole shoes should be worn.

CATARACTS

Cataracts were present in 16 cases, a higher incidence than in Barach's group (39 cataracts in 317 patients). We agree with Barach that the cataracts in the older diabetic are usually of the senile type. Corneal arcus, which was present in 10 patients, recently has been considered an indication of atherosclerosis (Adlersberg), and in this sense, is not truly an ophthalmologic condition.

BENIGN PROSTATIC HYPERTROPHY

Benign prostatic hypertrophy was present in 12 of the 36 male patients, many of whom underwent surgery.

CHRONIC INFECTION

Chronic infection was present in 11 patients, one of whom harbored both chronic conjunctivitis and chronic bronchitis.

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Diabetes Mellitus and Obesity

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WHILE heredity determines the individual susceptible to diabetes, the most important of all predisposing factors is obesity. In an analysis of Joslin's cases from 1898 to 1928, by Joslin, Dublin and Marks,[1] the high incidence of obesity is evident.

STATISTICS

Among 4,596 patients (20 years of age and over) 78.5 per cent of the males and 83.3 per cent of the females were overweight. In 3,094 cases analyzed at the onset of diabetes it was revealed that 62.7 per cent of the males and 67.4 per cent of the females were overweight. One-half of the men and almost 60 per cent of the females were at least 20 per cent overweight at their maximum weight. 16.5 per cent of the men and 25.8 per cent of the women were 40 per cent or more overweight at their maximum. In all groups there is a greater tendency for obesity among diabetic women than among diabetic men.

OBESITY IN THE JEWISH RACE

The tendency to obesity among Jewish[2] diabetic patients is even greater. 86.8 per cent of the diabetic Jewish men were overweight at their maximum prior to the diagnosis of diabetes, compared with an incidence of 78.5 per cent for all adult males. Among Jewish women 94.3 per cent were overweight at their maximum compared with 83.3 per cent for all female patients. 58.4 per cent of the Jewish men were at least 20 per cent overweight as compared to 51 per cent for total males. 77 per cent of Jewish women were at least 20 per cent overweight as compared to 59.3 per cent for the total females. The comparison of males 40 per cent or more overweight was about the same for Jewish males as for all males. Jewish women, however, 40 per cent overweight revealed an incidence of 33.5 per cent as compared with 25.8 per cent for all diabetic women.

Duncan[3] states that "70 to 80 per cent of diabetic patients are, or give a history of having been overweight and yet in the reception room of a physician specializing in the treatment of diabetes there is no such predominance of the obese." Many diabetic patients who first present themselves to a physician for treatment have lost weight due to the uncontrolled metabolic state. This results from loss of sugar and at times ketone bodies with no great reduction in the caloric intake.

Armstrong, et al.,[4] in a recent survey of the weight of persons developing diabetes after 40 years of age, found that approximately 60 per cent had previously been greatly overweight, and an additional 25 per cent had been moderately overweight. 15 per cent did not give a history of obesity preceding diabetes.

According to Bortz,[5] the number of individuals who are or were fat and subsequently developed diabetes is variously estimated at from 55 to 80 per cent.

INFLUENCE OF OBESITY

The important influence of obesity in the development of diabetes explains many peculiarities in the distribution of the disease according to Joslin.[2] In conjugal diabetes, but one of 27 partners was thin. This is further confirmed by the fact that the frequency of diabetes in the Jewish race has a great deal to do with the existent obesity. Many authors have alluded to the greater frequency of diabetes in city workers in contradistinction to country workers. Obesity and activity of the muscles seems to best explain these differences.

Whatever increases the possibility of becoming obese in those hereditarily predisposed to the disease will tend to bring about a real increase in the incidence of diabetes. The development of obesity in the hereditarily susceptible diabetic individual is likely to precipitate diabetes.

According to American statistics, diabetes is less frequent in rural communities than in urban communities. The question, of course, that arises is whether the lighter work done by individuals of the urban population accounts for these figures or is medical diagnosis and detection better in the urban areas. On the other hand, income parallels the diabetic incidence. It has been shown that where the income is lowest, so is the incidence of diabetes. Obesity tends to develop with inactivity. Stock and poultry growers know that animals can be fattened for the market by limited activity and over-feeding.

In the human being a like process may take place. The increased use of power and machines tends to offset the need for human labor and to

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encourage obesity. The high earnings of laborers in this country tend to elevate the standard of living and also tend to the development of obesity. The lessening of working hours in this country with more time for leisure also aids in the greater tendency to obesity. The tendency of the population to move to urban areas where life is easier tends also to increase the incidence of diabetes. The position of women in this country has changed also. Women now have less heavy work to do and for the first time in the history of the United States, now outnumber the men.

Dublin and Marks[6] investigated the incidence of diabetes in men above 6 feet and 2 inches in height. They found that there was normal mortality and a normal pattern of causes of death in this group. Only in the obese in this group was the mortality from degenerative diseases high.

According to Hanhart,[7] of Zurich, the incidence of diabetes is less in Europe than in the United States, because there is less obesity in Europe as a result of the meagre food supplies.

Diabetic children are usually not overweight so obesity is not an important predisposing cause of juvenile diabetes. However, a fat child usually signifies a fat adult and especially if there is a history of heredity to diabetes in such a family such an individual is most susceptible to the development of diabetes. Rarely diabetes may follow drastic weight reduction. The cause for this is unknown.

INTRINSIC RELATIONSHIP OF OBESITY TO DIABETES

Clinicians have long recognized the high incidence of obesity among diabetic patients. Allen[8] showed over 30 years ago that partial pancreatectomy in dogs had no apparent effect when they were eating in the usual manner, but diabetes developed when the dogs were overfed. Physicians have known for a long time that diabetes is ameliorated when the body weight is reduced by decreasing the caloric intake. The total food intake rather than the available carbohydrate is more important in the production of obesity. Ordinarily, most obese diabetic patients have mild diabetes except for those whose increased weight is due to a high caloric intake with the administration of insulin. According to Duncan,[3] the obese diabetic patient is relatively resistant to insulin.

Arterial degeneration and hypertension are more common in the obese diabetic patient than in the non-obese diabetic patient. Reduction in weight of the diabetic patient has a more favorable influence on hypertension than in the non-obese diabetic patient. Reduction of weight will tend to prevent as well as to lessen the degree of degenerative arteriosclerotic changes in the arteries of the diabetic individual.

While all of the aforementioned statements have been fairly well accepted by the medical profession, the exact relationship of obesity to diabetes has not yet been clearly defined. We have all generally accepted the statement that obesity is the result of an excessive intake of calories over the total expenditure of energy. We have berated the obese individual for overeating and for his excessive appetite. In general, the feeling of the majority of the medical profession coincides with that of Bortz,[5] who states that the chief cause of exogenous obesity in 99 per cent of cases is due to an excessive food intake. He further intimates that only 1 per cent of cases of obesity result from the endogenous or the hormone type.

RECENT EXPERIMENTAL WORK

Despite the clinical significance of obesity very little experimental work has been done with respect to this condition. Recent research work in animals indicates that under certain experimental conditions the voracious appetite and obesity can be produced with renal and vascular disease and eventually the appearance of glycosuria. Long[9] has shown that suitable bilateral hypothalmic lesions placed by electrolysis in the brain stem of rats or monkeys lead to the development of an enormous degree of obesity. Rats weighing over 1000 grams and macaques whose body weight increases from 3 to 18 kilograms in a few weeks may be produced by these means. The cause of the obesity is the intense voracity which develops as soon as the lesions are made.

A certain portion of these obese animals develop a progressive impairment of carbohydrate tolerance which is noteworthy because in the rat the pancreas is more resistant to insult than in others. If the pancreas of the rat has been partially removed but not to the extent to cause glycosuria, the development of voracity and obesity that follows the placing of such brain lesions is at once reflected by the presence of glycosuria. As Long[9] points out, the greater importance is the observation that after obesity has persisted for a while, reduction of food intake to normal levels no longer results in a disappearance of the glycosuria. The fat metabolism in these animals is apparently normal and the conclusion is that the impairment of carbohydrate tolerance is a consequence of a relative insulin deficiency.

In 1945, Mirsky[10] contemplating the reason why obesity so frequently precedes the development of diabetes in man, suggested that the obesity is due to a relative excessive intake which in turn is preceded by an increase in appetite. He felt that obesity instead of being regarded as an etiological factor in the genesis of diabetes represents that phase of diabetes in which an increased rate of insulin utilization or destruction, is adequately compensated for by the pancreas.

In those instances where the rate of insulin utilization continues to be excessive and beyond the capacity of the pancreas to produce insulin, diabetes will become apparent.

HEREDITARY OBESITY-DIABETES SYNDROME IN MICE

Recent animal experimentation has led to other approaches to the problem of obesity and diabetes. Ingalls et al.,[11] produced a strain of mice that show hereditary obesity.

Mayer et al.,[12] found that the obese mice voluntarily ate a diabetic-like diet which resulted in further metabolic studies of the carbohydrate metabolism in the obese mice.

Mayer et al.,[13] revealed that these fed obese mice had a blood sugar level usually above 200 mgs. per 100 cc., whereas non-obese animals had an average blood sugar level of 110 mgs. per 100 cc. Fasting for a four hour period resulted in a 50 to 60 per cent drop of the blood sugar level of obese mice, whereas very little change was noted in the blood sugar level of the non-obese mice. The obese mice were insulin resistant to massive doses of insulin while the non-obese animals presented a normal insulin sensitivity.

Bleisch et al.,[14] have studied a strain of obese mice, with constantly associated diabetes and insulin resistance. This strain has been studied in comparison with clinically normal siblings and parents and Swiss mice.

The obese mice exhibit larger, more numerous islands of Langerhans and other evidences of a stimulus to island growth. The siblings revealed slight evidence of a similar stimulus. Structural changes of other endocrine organs were not demonstrated. The obese mice have less than normal amounts of hepatic glycogen. In some of the obese animals cutaneous atrophy and ulcers were found which did not heal.

The association of changes in the islands of Langerhans, with insulin resistance and hyperglycemia suggests the existence of an insulin antagonistic factor which results in island growth primarily or secondarily. The authors point out that this may be an inherent metabolic antagonist.

The low liver glycogen content in obese mice and the lability of blood sugar levels implicates the glycostatic theory of the regulation of the appetite in the causation of the obesity and possibly of the diabetes.

STUDIES OF PYRUVATE AND ACETATE METABOLISM

Studies earlier by Guggenheim and Mayer[15] of pyruvate and acetate metabolism in the hereditary obesity-diabetes syndrome of mice, revealed some interesting facts. It was found that when fasted, obese and non-obese mice were injected with carboxyl-labeled sodium acetate, the non-obese mice excreted one-third more labeled CO_2 during the 3 hours following injection than did obese animals. When obese and non-obese animals were fed labeled acetate for 3 days, the over-all incorporation of acetate was more than twice as great in the obese as in the non-obese. By means of carboxyl-labeled pyruvate it was shown that pyruvate oxidation was depressed in the obese animals. The partial block of acetate utilization and the resultant increased lipogenesis are considered by the authors to represent the primary hereditary biochemical lesion in the syndrome.

Further studies by Mayer et al.,[16] make it possible to reconstitute the probable succession of events and to describe the etiological mechanism of the hereditary obesity-diabetes syndrome. The genetic lesion is a Mendelian recessive partial block of the oxidation of C_2 fragments preventing lipolysis and diverting the utilization of the pyruvate derived from carbohydrate (and from a small part protein) into synthesized fatty acids.

Thyroxine administration, though its effects are somewhat temporary and variable seems to facilitate oxidation of the depot fats of the obese mice and apparently removes in part the primary genetic block. The simultaneous administration of diethylstilbestrol considerably increases the toxicity of thyroxine, because of the depression of pituitary function while the metabolic rate is being increased. There is a second block at the C_6 level indicated by the fact that glucose ingestion gives rise to hyperglycemia while fructose does not. This implicates the hexokinase reaction. The block is effected by growth hormone, with the hormones of the adrenal cortex playing to a certain degree a permissive role. Increased insulin resistance is the result of increased growth hormone effect.

The hyperglycemia is progressive and begins between the ninth and tenth week. The obese animals lose weight on a high fat and high vitamin diet. A high protein, carbohydrate diet checks the rapid weight increase and suppresses glycosuria without the deterioration which occurs in the former group. A glucose free, fructose containing diet suppresses glycosuria but does not check weight increase. Non-obese animals are not affected by these diets. Growth hormone precipitates the onset of hyperglycemia in young obese and doubles the blood sugar content of the obese animals. Growth hormone had no effect on the blood sugar level of the non-obese animal. Obese animals were extremely sensitive to pancreatectomy and fatally affected by corticotropin administration.

TREATMENT

It has been shown that suitable bilateral electrolytic lesions in the hypothalamus of rats and monkeys lead to a voracious appetite, obesity and in certain instances, progressive impairment of

carbohydrate tolerance. A strain of mice exhibiting recessive Mendelian obesity, with constantly associated diabetes has been studied. These obese animals on a free choice experiment, select diets much richer in fat than the non-obese. From these experiments in animals, one can conclude that a disorder of appetite may result from an acquired or inherent disturbance of the central nervous system or because of an hereditary pattern.

At the present time, there is no proof that similar mechanisms occur in the human being although the future may change our present concepts.

The treatment of the obese diabetic patient consists in the administration of an intake of calories lower than the expenditure of energy. All authorities agree that the obese diabetic patient should be reduced in weight. Many authors have shown that the diabetes can be greatly ameliorated by reduction of weight. Successful treatment of obesity is much easier said than done. A sympathetic understanding of the patient's problems is the most important factor in gaining his cooperation.

Many physicians prescribe a diet of 1000 to 1200 calories sufficient to cause a weight loss of one to two pounds a week and until the urine is sugar free. The total caloric value of the diet is one of the most important factors.

Duncan[17] using a more refined formula suggests that to estimate the basic caloric requirements for 24 hours, that the ideal body weight in pounds be multiplied by 10. Deduct 100 to 200 calories if the patient is elderly, short or female, or if the patient is obese, subtract 200 to 400 calories. The carbohydrate allowance in such a diet would vary between 100 and 125 grams daily. The protein in the diet can be calculated by multiplying the ideal weight in pounds by 5/8. The balance of the calories to complete the diet is derived from fat. When the weight has been reduced to the proper level, the calories can be increased to maintain weight.

Most authorities agree that the use of insulin is contraindicated in most obese diabetic patients except in those having complications. Insulin stimulates the appetite and therefore tends to increase the weight of the patient more. Insulin favors the transformation of glucose to fat. In most obese diabetic patients the diabetes is mild, and many of these patients are relatively insulin resistant.

The use of anorexigenic drugs has been favored by Osserman and Dolger[18] because of inability to maintain adequate dietary control in a large group of patients. No immediate adverse effects upon the diabetic state were noted. Other authors feel that the use of such drugs de-emphasize the importance of the diet.

The closer such patients can be kept under observation, the more success one will have with respect to their treatment.

SUMMARY AND CONCLUSIONS

1. In human beings, heredity determines the individual susceptible to diabetes.

2. Analyses of major available statistics indicates that especially in adults, obesity is the most important predisposing factor in the development of diabetes.

3. There is a greater tendency to obesity among the Jewish race, and women although studies reveal the fact that the majority of males were overweight also.

4. According to statistics, diabetes is more prevalent in the urban areas than in the rural areas, probably as a result of lessened physical activity among the urban population.

5. The majority of obese diabetic individuals have mild diabetes.

6. Arterial degeneration and hypertension are more common in the obese diabetic patient than in the non-obese diabetic patient.

7. The exact relationship of obesity to diabetes has not yet been clearly defined.

8. Suitable bilateral hypothalamic lesions produced by electrolysis in the brain stem of rats or monkeys lead to the development of a voracious appetite, obesity and in a certain portion of the animals a progressive impairment of carbohydrate tolerance.

9. Recent animal experimentation reveals that a strain of mice has been produced that shows hereditary obesity and diabetes.

   a. These mice have high blood sugar levels that can be reduced by fasting.

   b. They exhibit larger and more numerous islands of Langerhans and other evidences of a stimulus to island growth.

   c. The obese mice have less than the normal amount of hepatic glycogen.

   d. The obese diabetic mice are relatively insulin resistant.

   e. Pyruvate oxidation was depressed in the obese animals. The partial block of acetate utilization and the resultant increased lipogenesis are considered to represent the primary hereditary biochemical lesion in the syndrome.

   f. The genetic lesion is a Mendelian recessive partial block of the oxidation of C_2 fragments preventing lipolysis and diverting the utilization of the pyruvate derived from carbohydrate (and for a small part protein) into synthesized fatty acids.

   g. There is a second block at the C_6 level indicated by the fact that glucose ingestion gives rise to hyperglycemia while fructose does not.

10. The treatment of the obese diabetic pa-

tient consists in the administration of an intake of calories lower than the expenditure of energy.

11. The use of insulin is contraindicated in most obese diabetic patients except in those with complications.

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Low Sodium Diet

There has been a considerable accumulation of reports that a depletion of sodium in the diet is of benefit in essential hypertension. That the sodium intake has not been sufficiently reduced in the past is significant, though the importance of doing this was demonstrated in 1922 by Allen and Sherril. The latter concluded that essential hypertensive patients did better if the sodium radical was restricted to about 200 milligrams per day. This standard is now well accepted.

Bryant, Iob, Philips and Blecha have devised a simple urinary test which informs patients whether in the preceding twenty-four hours they have partaken of more than 200 milligrams of sodium. This test, though not scientifically accurate, is a good clinical test to guide the patient, as a Clinitest® tablet test guides the diabetic.—George G. Ornstein, M. D., and Lawrence Lercher, M. D., New York, N. Y.:*J. M. Soc. New Jersey*, 50:294, July, 1953.

KEEPING UP WITH MEDICINE

• STAPHYLOCOCCI fortunately seem to be the only organisms that become readily resistant to penicillin but these resistant forms are now a matter of considerable concern, more perhaps with the English than with us.

* * *

• LIKEWISE it is not uncommon to encounter strains of the tubercle bacillus which have the ability to multiply and thrive in concentration of streptomycin several thousand times as strong as was necessary to suppress growth ordinarily.

* * *

• AS TO THE manner in which these germs acquire this resistance, some penicillin-resistant staphylococci produce an enzyme, penicillinase which rapidly breaks the pencillin into the inactive penicilloic acid.

* * *

• OTHER BACTERIA owe their resistance to the short-circuiting of some important metabolic process which is blocked by the drug. For example, under some condition the penicillin-treated staphylococci are unable to take up an essential nutrient—glutamic acid—from their environment and thus their growth is suppressed.

* * *

• IT IS COMMON knowledge that sulfonamide drugs inhibit the growth of bacteria by preventing their use of p-aminobenzoic acid through the substitution of an analog which is useless to the germ. More recently it has been found that these organisms at times develop the property of forming perfectly huge amounts of the essential nutrient, enough in fact to swamp the sulfonamide and allow full growth of the germ.

* * *

• LIKEWISE those who need glutamic acid often develop the power to make it in abundance from simpler compounds.

* * *

• SOME WORKERS feel that in a few successive steps changes take place spontaneously and rapidly in the cells of some bacteria of a colony in the presence of a drug and that these "mutations" now have the ability to survive and send the same power down to succeeding generations.

* * *

• OTHERS ARGUE that the transformation to a resistant form is often too gradual and continuous a process to be explained by sudden mutations. It frequently involves, they point out, all of the cells of a colony and seems to be due to a specific action of the drug by which the pattern of the bacterial metabolism is gradually remolded over a number of generations. One example of such an adaptation is the formation of penicillinase to destroy the drug whenever it is encountered.—J. F.

Arteriosclerosis and Heredity in the Diabetic

O. P. ALLEN, M. D.

ARTERIOSCLEROSIS is generally thought of as a disease with a single cause. In the over-all picture, one must take into account inheritance, genetics, development of normal adult resistance during growth up to maturity, inroads on the margin of safety, total amount of damage encountered up to maturity and beyond, and the aging and involution which takes place after maturity; plus infections or toxic states, acidosis, trauma and also the resulting damage to other parts of the system often far removed from the original source of trouble.

HOW DISEASES FOLLOW GENETIC LAW

Mendel discovered the gentic law which governs inherited characteristics. Many diseases have been observed to follow this law, and the probability of passing along a characteristic from one generation to the next can be predicted with reasonable accuracy. The chromosomes, of which there are twenty-four pairs in man, are represented as paired chains of genes. At any given site, only one gene can occupy a given space on a chromosome.

As chromosomes are paired, there are two genes for every characteristic. When the genes on the paired chromosomes are the same, they are called homozygous. They may be either dominant or recessive and be homozygous. The term allelomorph applies to two or more genes of the same character; but one or both may be dominant, or both may be recessive, or one dominant and one recessive, or a variant of either due to environmental conditions in different individuals. When different allelomorphs are present, the organism is heterozygous.

The degree to which a variable allelomorph is expressed may be true to the dominant or have a marked variance to either of the two individuals involved.

Sometimes in the male there is one of the pairs of chromosomes unlike all the others, in that in the male the chromosome has a mate which does not function. If the gene which determines the character is in this pair of chromosomes it is called "sex-linked type." It is passed through the female line to the male siblings, sometimes for many generations without appearing in any member of this family. Before this "sex-linked" character can be expressed, it must be paired with another "sex-linked" chromosome. A single trait can be modified by several pairs of genes and can be varied toward greater dominance, or interfere with expression of trait even to complete suppression.

Submitted August 29, 1953.

The Author

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Under these conditions of heredity, it may be possible to establish a new family characteristic which may become a fixed inherited trait. If this should happen due to environmental changes, it may be possible to develop a familial strain with a protein that has a poor resistance to infections, toxic or acidotic states. This could account for some people who seem to develop a dysfunction without any inheritance for that type of syndrome. Any of the foregoing often repeated before maturity would interfere with the full development of normal resistance and the total would be less than normal at maturity; therefore, less able to stand repeated injury of same type.

METABOLIC OVER-STIMULATION IN THE DIABETIC

After maturity has been reached, we come to the period of wear and tear in which infection, toxemias, traumas, over-stimulation due to emotional stresses, dietary abuses, exposure and exhaustion and also metabolic disturbances, which place an overload on a weak, resistance-poor, easily damaged protein. When these periods are severe enough or repeated enough, the total overload may start a train of symptoms which may set the picture for metabolic over-stimulation in the diabetic, as described by myself[1] in *The Ohio State Medical Journal*, (March, 1953).

In most instances of dysfunction such as we see in diabetics, we first have some acute episode which upsets the normal metabolism. This may be temporary with a return to normal function or it may be a stimulation or depression which causes a greater amount of work to be done by the organ or system affected. Later, the stimulation is followed by a gradual diminishing inability to do the normal amount of work.

Now we have a depression of ability to perform the normal function and usually symptoms appear that are recognized and a name attached as a

disease entity, when it is truly a lack of ability to perform the normal amount of work which will support one individual in reasonable state of health. The condition treated as a disease, is frequently the end result of damage which occurred months or years previously.

The aging is a part of the progressive damage and involution is the change requiring long periods of time to develop to the point of causing sufficient inconvenience to make the patient ask for help from his doctor.

The aging and involution include such changes as collections of cholesterol in arteries and gallbladder, excess fat accumulation, chalk and calcium deposits in the joints, etc. Aging also includes day to day living, injuries, toxemias, infections, worry due to emotional upsets, dietary indiscretions, exposure to sudden changes of temperature, excessive physical effort without conditioning and many other types of abuses.

Far removed damage from the original damaging process is seen best probably in the toxic effect on the kidney, following scarlet fever or appendicitis, following a sore throat or some arthritic or neuritic effect far removed from an abscessed tooth, which takes considerable time before it is found and the source of the toxic state or septicemia is removed.

ARTERIOSCLEROSIS

The average age at which arteriosclerosis makes itself known is variable, but the average is about forty years. The onset of symptoms is the warning that damage has been going on for some time, probably since maturity. At maturity the maximum ability to function efficiently has been reached and also the greatest resistance to toxic damage or damage from any source has been accumulated in sufficient quantity to protect the individual through many bouts of damaging illnesses.

From this point on as aging occurs, every infection, toxemia, or trauma is an overload which is a challenge to be overcome and the damage repaired as efficiently as possible so the whole system can function as near the peak as possible, minus the total fixed damage that cannot be repaired. Total resistance, minus the fixed damage is the condition in which we find the patient when he presents himself for examination. This amount of resistance is the foundation on which we try to build his future well-being.

In man there is an inherent factor which gives an individual about eight times the normal capacity in the heart, lungs, kidney, liver and most other systems and organs. This is called the "margin of safety."

When an organ or system has received sufficient damage and the "margin of safety" is reduced to the amount of function which will support life, some vital part fails and the end result is loss of life, due to hemorrhage, thrombosis, infarct or loss of function with failure.

The initial thickening and scarring of blood vessels with cholesterol deposits and high blood cholesterol is not seen in those races which have little or no meat, eggs and dairy products in their diets. The diet seems to influence the level of cholesterol in the blood stream, but it takes several months to bring about a very slow reduction. The concentration returns to the higher level when a free normal diet is resumed.

The intimal thickening is increased in the male from birth as compared with the female. This probably predisposes to toxic damage and scarring and greater frequency of such episodes as cerebral accidents and coronary occlusion, as well as other vascular accidents. The inherited characteristic of intimal thickening may well be the original basis for the increased incidence of vascular sclerosis in the male.

In *The Journal of the American Medical Association* (July 18, 1953) in a report on findings on 300 male hearts of men killed in the Korean War, the average age being 22.1 years, 77.3 per cent of all cases examined showed varying amounts of coronary disease, from fibrous thickening to total occlusion. The plaque formation usually occurred at or near the bifurcation of vessels, and suggests the eddying of the blood at these points has much to do with their formation. These early beginnings of arteriosclerosis in a group with a low average age is markedly surprising and suggest a very early start of this condition shortly after maturity is reached.

RETINAL CHANGES

Having examined eye-grounds of over 3,000 patients, if diabetes is present, some signs of the disease is always found in the retinal blood vessels, such as:

1. **Increased number of blood vessels** emerging from the disc as fine arterioles, showing a demand for greater blood supply.
2. **Increased tortuousity,** a probable demand for increased blood supply to retina due to narrowing of lumen of optic blood vessels and increased pressure.
3. **Variability in caliber** may mean thickening of blood vessel wall which is weakened by toxic urticarial type damage with stretching at some points and constriction at other locations.
4. **Notching** at the crossing of artery over a vein, causing a compression due to arterial rigidity or increased pressure.

EARLIEST SIGNS

These are the earliest signs of arteriosclerosis in the blood vessels as observed in the retina. The youngest patient observed was 17 months of age with all of the above signs present. The history of this case was typical of the early

beginnings of diabetes in a family with diabetes present as a hereditary factor. The mother had toxemia of pregnancy which was the first toxemia encountered by this child.

The child was slightly overweight at birth and ate excessively during the first year and gained weight. Hunger recurring at a shorter interval than the usual four hour feeding period during the first year, showed a more rapid digestion and storage, hence an increased appetite. With this condition one is suspicious of a toxemia (of pregnancy) which has destroyed insulin and creates a demand for greater amounts of insulin to be produced. So that amount which is not destroyed is sufficient for normal metabolic needs and stimulates the pancreas to over-produce causing a hypoglycemia. When the toxemia disappears and the full effect of over-produced insulin depresses the blood sugar to hypoglycemic levels, it is because the pancreas fails to return to a normal production level.

At about one year, this child had a severe attack of cold with a sore throat and otitis media. This infection produced a second toxemia which in turn destroyed all the over-produced insulin and damaged or depressed the pancreas until the insulin produced was not sufficient to maintain normal metabolism of glucose. When seen at 17 months, this child was a diabetic with the retinal changes mentioned above. These being early signs of sclerosis, this child had started to damage her vascular system long before she ever reached maturity.

I am watching this patient very closely, hoping to see what the next step will be as the sclerosis progresses, with more toxic, traumatic or infectious damage.

INHERITED CHARACTERISTICS

Inherited characteristics of a family is one of the factors in the development of arteriosclerosis. It is aptly stated by Dock[2] that the way to avoid the disease is to have and be responsible for long-lived ancestors. In this one pertinent statement, he has linked the weakness of heredity to the wear and tear and damage encountered in the process of living.

Heredity in the diabetic is an inherited protein susceptibility to toxic damage. His protein does not resist well the inroads of repeated toxemias and/or recurrent bouts of acidosis, periods of stress, or the same type of injury occurring at frequent intervals, all of which cause a real metabolic problem to be combated and the injury or damage to the part or a system, such as the vascular, must be repaired. First the damaging factor must be controlled, damage stopped and time allowed for repair and elimination of waste products of repair which are frequently toxic and bring about a more acid state.

Rich[3] has demonstrated "urticarial wheals" in the walls of blood vessels. The urticarial wheal is a local edema. He also has shown local necrosis and inflammatory changes in arterial walls. Hawn and Janeway[4] have confirmed these findings. These conditions are brought about by toxic material in the blood stream and could be by any toxic state of equal virulence and concentration.

The Shwartzman phenomenon which produces localized hemorrhages, is due to a sensitized area coming in contact with the same or closely related toxin. It is possible to see how, due to some illness, bacteria or their toxic products could invade the blood stream and sensitize certain areas in blood vessels or organs; and sometime later, hours or days, the same toxin could come in contact with the sensitized area and produce a localized hemorrhage. This could, in a mild form, be the urticarial swelling of Rich which does not go on to hemorrhage, but causes hyalin degeneration, some necrosis and fibrosis, with later cholesterol deposition in the course of repair.

Later, due to the aging and repair, constriction of fibrous material which has been laid down, with thickening of the intima and this being constricted by scar tissue retraction, we begin to encroach on the lumen of a blood vessel with consequent embarrassment of circulation and begin to get dysfunction. This brings to the individual's attention that something is wrong about which he needs the help and advice of his physician. But the damage which is fixed is not of the reversible type; so the problem becomes one of educating the population to recognize these upsets, injuries, infections and illnesses which can produce the conditions discussed, and to avoid them as much as possible, and bring about repair in the shortest time to lessen the total fixed damage.

However, we only have that amount of total resistance given us by our ancestors through heredity and when we have dissipated our allotted amount, the system fails as a whole or in some vital part and the end result is death. A short life and a merry one, or with care and judgment, a long life without excesses or carelessness with our heredity.

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Alcoholism—The patient should be given a high calorie, high vitamin diet as soon as he is able to eat it, and therapy should include large doses of all the known B vitamins as well as vitamins A and C, plus whole B complex in the form of brewer's yeast or crude liver.—L. L. Tureen, M. D., *Missouri Med.*, 50:766, October, 1953.

Dietetic Management of Diabetes

HENRY J. JOHN, M. D.

THE dietetic management of diabetes is one of the oldest procedures in medicine. Before the insulin era it was all that we had to offer to a diabetic patient. In mild cases it meant just a reasonable reduction in the diet, restricting mainly the carbohydrates. In the severe cases a marked reduction in the diet and the calories was necessary, all the way down to 1000, 800, or 700 calories. This presented a severe dietary routine for this group of patients, so much so, that they became markedly emaciated. However, it meant either such a low caloric diet and prolonged life or else no restriction in diet and an early exitus. It was hard to be a diabetic in those days.

When insulin came in, in 1923, the picture changed remarkedly. No longer were such low caloric diets indicated, since we could place these patients on more liberal diets and make up for their endogenous insulin deficiency with exogenous insulin injections. It was a tremendous boost to these patients, for, once again they became normal human beings and could carry on their business or their occupations. These were the most appreciative patients for they knew the difference between what preceded and what followed after the insulin became available.

This change of increased diets was general. In fact some physicians went to the other extreme and placed their patients on very high caloric diets, 3,000 to 5,000 calories, making up their insulin deficiency with exogenous insulin. The result was that these patients soon became obese, an undesirable thing—especially in a diabetic—and thus soon this extreme procedure died out and patients were placed, by and large, on an adequate, reasonable diet and kept their normal weights, which is the proper procedure. A diabetic needs to keep his weight normal and not be overweight. This is a point which has been shown and proven over and over again. See F. M. Allen's experimental work on animals and patients in this respect.[1]

While this meant at the beginning, that these patients had to take two to four injections of insulin a day, they were glad to do this in order to keep fit. In time came the newer insulins with a prolonged action, the Protamine Zinc insulin, the Globin insulin and now the NPH insulin which reduced the discomfort to one or at most two injections a day which is the status today. What an improvement it was, especially in the case of the diabetic children! But the thing to remember and to emphasize to patients is the fact that "insulin will not do the job alone"; that they still have to adhere to a diet, but now an adequate diet which no longer presents a hardship. But, diet nevertheless.

Submitted August 18, 1953.

The Author

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Such an original procedure which we followed over decades, and many physicians follow still, was to teach the patient the carbohydrate, the protein, the fat content of the various foods and to calculate the calories in these foods. This was a simple enough procedure among the intelligent patients, but it presented a rather difficult problem among the diabetics who lacked education or those of foreign nationalities, many of whom had developed their own eating habits before diabetes occurred. Here a problem of instruction became a real problem, for many could not even read English.

Thus, a short-cut instruction developed where several sample diets were worked out for the patient by the dietitian for the three meals a day and the patient was instructed to follow this simplified schedule. This often became very monotonous for the patient and sooner or later, the patient would abandon it and eat as he or she liked. Not a logical procedure, but an explainable one from their point of view. This of course led to all kinds of difficulties and upsets of their diabetic state and often to an early end which could have been prevented.

PRESENT DAY DIET PROCEDURES

What is the status of diets today?

There are three schools in this country at present:

1. Those who still advocate the weighed or measured diets with no deviation from them.
2. Those who disregard any type of diet whatsoever and do not insist on any control of the diabetic condition from the laboratory standpoint.
3. Those who have liberalized the patient's diet but who insist on proper control of the patient's diabetic state.

WEIGHED OR MEASURED DIETS

Let us take Number 1. There is nothing wrong with this procedure, for that is the old orthodox procedure and works well. Only two things should be emphasized here: (a) that the diet is adequate for the patient's needs to enable him to

maintain a normal weight and energy, and (b) that he is not losing too much sugar in the 24-hour urine which would reduce the caloric diet by just that amount as is excreted as sugar in the urine. Thus if such a patient is losing, let us say, 75 Gm. of sugar in the urine each 24 hours, and is taking, let us say, 180 Gm. of carbohydrate a day, he is actually getting use of only 105 Gm. of carbohydrate of his food intake.

Intelligent patients do well on this routine.

NO DIET RESTRICTION

Number 2: No restriction of diet, no sugar-free urine, no control of hyperglycemia, in other words doing practically nothing for the patient. This is something which is hard to understand—how any physician could reconcile himself to such a procedure. The advocates bring up this argument: that it has not been shown that persistent hyperglycemia does any harm to the diabetic. On the other hand, we can say that if such a patient carries normal glycemia, this is physiological and therefore logical and eliminates any speculation. These patients get along well for a while, but the answer is: How will the statistics in this group compare with the statistics of Number 1 in the course of two or three decades? We still do not know, but one would predict that the comparison will not justify the procedure. Time will tell.

LIBERALIZED DIET WITH CONTROL OF THE DIABETIC STATE

Number 3: This is the procedure which I have adopted, and which amounts to this: No sugar, no pastry, no soft drinks and not more than one glass of milk in the case of adults if they wish it, not more than two slices of bread with each meal or if the patient takes one helping of potatoes he leaves off one slice of bread. Of the rest of the food, he eats whatever is on the table the same as the rest of the family, only that he is asked to eat in moderation and to watch his weight. If he is gaining weight, this indicates that he is eating more than he needs to, and he must cut down on his food intake.

Such a directive is extremely simple. Having cut out the previously mentioned articles of food, this presents no hardship; thereby we have cut out from his diet the high carbohydrate containing foods and he is, while he may not realize it, on a diabetic diet without being subjected to an extensive course of instruction on diets and what is even more important, he is eating what the rest of the family eats and does not have to feel sorry for himself. This in itself is a great psychological factor.

ADJUSTING THE INSULIN DOSAGE

Now comes the second part of his program: Adjusting the insulin dosage to his needs to enable him to utilize what he eats. This I have solved by taking the blood sugar before each meal (roughly 3 hours after eating), at 8 a.m., 11 a.m., 3 p.m., to see whether or not the blood stream has cleared itself of excess of sugar within 3 hours after eating, same as it does in a normal individual, a non-diabetic. If it has, which means normal blood sugar throughout the day, then I know that such a patient is thoroughly controlled, that I have returned him to normal physiology. More than that no one can do.

Whether or not there is glycosuria is of no consequence for if that patient has three normal blood sugars throughout the day, we cannot give him more insulin without producing hypoglycemia with all its bad effects. And this is exactly what happens if such a patient's insulin dosage is guaged by fractional urine examinations alone. If there is a heavy glycosuria the patient is directed to take "extra" 6 to 10 units of insulin upon the finding of glycosuria during the day and, what is most important, his blood sugar at the time of the glycosuria may be anywhere from 28 to 46 mg. per 100 cc.,[2] namely he is already in hypoglycemia and his insulin dosage needs to be reduced in place of increased.

Such blunders I see frequently in practice. It is the old teaching which should be abandoned and proper modern methods instituted. By producing a chronic hypoglycemia in this manner is not without danger, for it may affect the intellect of the child or the adult in time, a fact we need to bear in mind.

INSULIN REQUIREMENT

The next question comes up: Can we manage diabetic patients on diet alone? Yes, many we can, especially the older patients. Here the all important problem arises, namely, how early have we gotten the diabetic patient after he developed diabetes? If soon after, the chances are good that the diet alone will suffice. The longer he has had diabetes, the less chance that he or she can be managed on diet alone, although even here there are exceptions. Children and young adults as a rule cannot be managed on diet alone and do require insulin.

Another question that comes up is this: Once insulin is started, does it have to be continued the rest of the patient's life? This seems to be the common conception of diabetics. But it is not true! Some do, others do not. We often start diabetics on insulin at the start to save time in the hospital or the office and reduce, thus, his expenses and cut short the original hyperglycemia they have which is important. Then, as they improve, the dosage can be reduced and often eliminated.

Take for instance Chart I, Case 1, which is a record of a diabetic woman 54 years of age in 1949. For 9 months she used insulin and was on

a liberalized diet such as I previously described, to date. Then in April 1950 all insulin was discontinued and she has been on diet alone. Yet note the good control throughout the subsequent years to date, without insulin. She is of normal weight and keeps it steady, which tells me that she is not overeating. Remember that "it is not what a diabetic eats, but HOW MUCH he eats" which is important. And yet she shows glycosuria part of the time. This, however, in the presence of normoglycemia throughout the day is of no significance and does not indicate that she needs insulin.

Another question enters into the problem of fractional urines which is this: take a gram of glucose and dissolve it in 20 cc. of water, and another gram of glucose and dissolve it in 1000 cc. of water. Examine the two and you will see that the first will show brick red and the second only a trace and yet there is the same amount of glucose in both. I think that this factor has often been overlooked and yet it is quite important in the evaluation of glycosuria. The most important point regarding urine examination is the quantitative estimation of urine sugar, as to how many grams of sugar that patient is excreting in 24 hours. This gives a valuable information, whereas the fractional urines often give misinformation and lead to trouble.

Or let us consider Case B, in Chart I. A little girl, 15 years of age. This is to show that even the young do well on such a routine of liberalized diets. Note the steady and smooth progress over a several months' period and also the glycosuria when the blood sugars throughout the day are normal.

TREATMENT

What can we say about the dietary treatment of diabetes at the present time?

1. Many diabetic patients can be managed on diets alone without insulin. This applies for the most part to the older patients and also to the

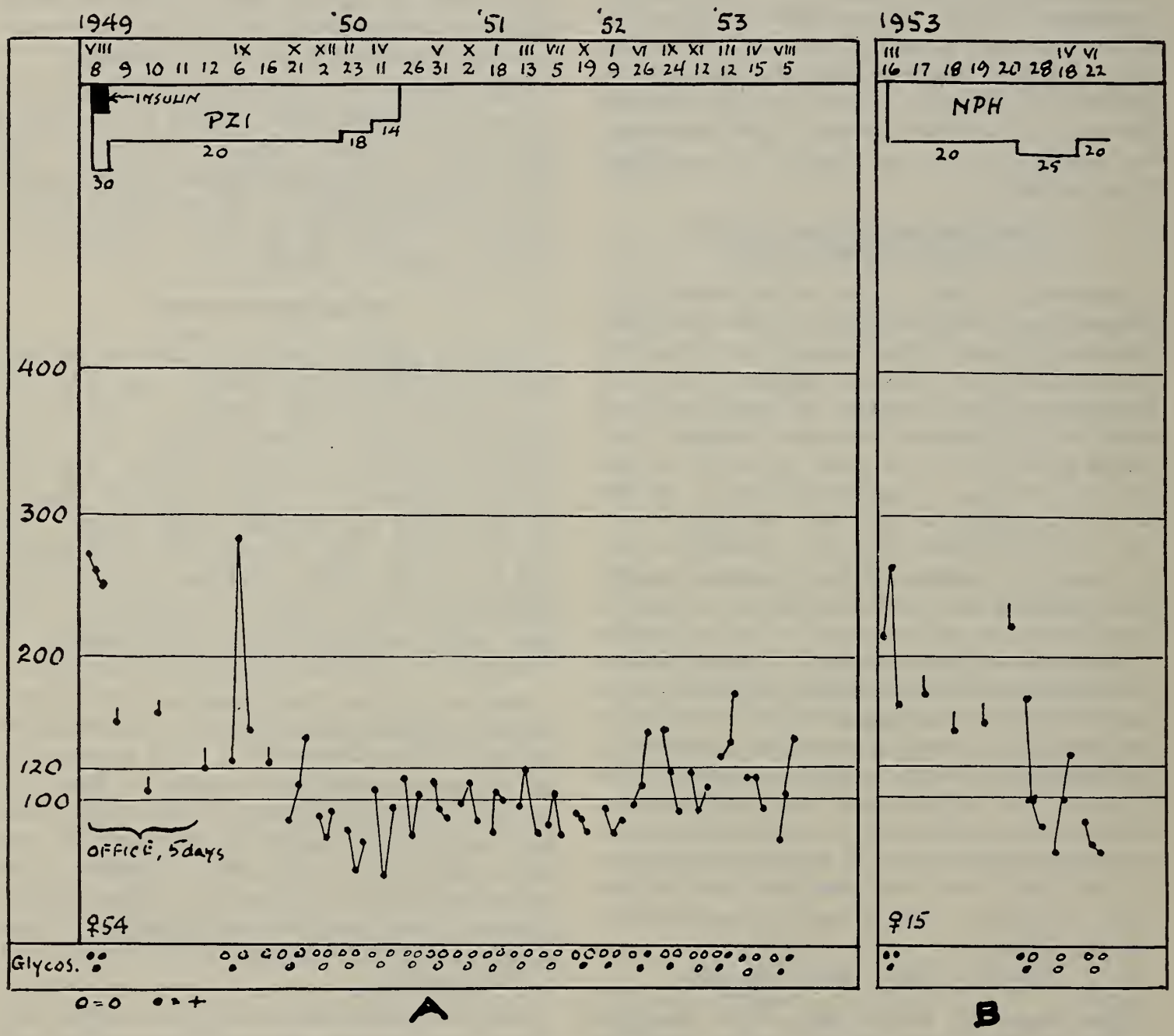


CHART I.

obese patients who are placed on low caloric diets in order to reduce their weight.

2. The majority of diabetics have to use insulin in addition to the diet prescribed for them.

3. Any diabetic who is either on diet alone or diet and insulin and whose weight is normal, should get adequate calories so that he can maintain his normal weight and energy. If he is losing weight this means that either he is not getting enough food each day or that he is not getting enough insulin to enable him to metabolize fully that which he eats.

4. Any diabetic who is obese should be placed on a low caloric diet so as to enable him to reduce his excess weight somewhere near to normal. Such a low caloric diet often is adequate in itself so that the patient need not take insulin. This point of course must be ascertained by proper laboratory investigation.

5. Making fractional urine examinations is not the proper procedure for the evaluation of a diabetic control; glycosuria can be and often is present when the patient is already in hypoglycemia at the time. What is needed is the estimation of the blood sugar, three times a day, before meals, which will prevent the blunders of giving more insulins just because of the finding of glycosuria, to a patient whose blood sugar is already 28 to 46 mg. per 100 cc., when he needs food in place of more insulin.

6. While liberalized diets do work well if properly controlled by laboratory studies, these should not be used indiscriminately without such control. They make the patient's life an easier and happier one and are infinitely simpler and, if properly controlled, they are the logical answer to the patient's diabetic problem.

7. Glycosuria is **not an index** to glycemia, for these two do not run parallel with each other.

SUMMARY

8. To summarize: Adequate caloric diet for the diabetic patient and ascertaining that he is utilizing such a diet, whether this had been prescribed by the physician or selected by the patient himself so that we can be sure that he is utilizing it and also that he is not gaining superfluous weight, is the essential thing. Such a patient if controlled is avoiding many complications in the subsequent years and many degenerative changes which occur in uncontrolled diabetics no matter what routine they are on. These are just common sense measures. The life of a diabetic is hard enough and we should not make it harder for him unnecessarily.

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Diarrhea a Danger Sign in Patients Receiving Antibiotic Drugs

A diarrhea developing in a patient receiving aureomycin or terramycin® constitutes a danger sign. Smears of stool material stained by Gram's staining method must be made and if Gram positive organisms dominate in the bacterial flora, the drug must be stopped immediately. Postponing the treatment until a culture is developed may be too late, since the patient may die in the meantime.

It is suggested that erythromycin be given orally, since this drug is said to inhibit micrococcal growth with only negligible effects on the coliform bacilli. The signs and symptoms of micrococcal dominance are diarrhea, shock, anuria, and uremia. Immediate cessation of the use of terramycin® or of aureomycin is imperative in this condition.—A. L. Tatum, M. D., Madison: *Wisconsin M. J.*, 52:417, July, 1953.

Antihistamines as Local Anesthetics

The local anesthetic property of the antihistamines was known as early as 1939. Since that time, numerous papers have been written, both experimental and clinical, declaring their advantages over the more commonly used drugs. Yet they have achieved little popularity as anesthetics except as antipruritics in various dermatologic disorders.

The antihistamines have been shown to be satisfactory agents for nearly all types of conduction anesthesia. Not only are they more potent and longer acting in many instances, but they almost entirely lack the undesirable side effects of the conventional agents.

The method and site of application have considerable influence on the time of onset and the duration of anesthesia. A swab of 1 per cent pyribenzamine® applied for 10 seconds to the lip and tongue produces loss of taste in 30 to 40 seconds, numbness in 2½ minutes and anesthesia to pin prick in 4 minutes. A period of 10 to 15 minutes is adequate for the passage of the gastroscope or for corneal anesthesia. Applied by swab for 10 seconds to the tongue, this drug induces anesthesia which may be expected to last for about 10 to 15 minutes and as applied in gastroscopy for 40 to 90 minutes.

Pyribenzamine® 2 per cent in water-soluble ointment base applied to hemorrhoids lasts from 1½ to 2 hours. More prolonged anesthesia may be attained by repeatedly wetting cotton wicks or pledgets in place about every 45 to 60 minutes. One factor probably concerned in prolonging the effect is the ability of the antihistamine to produce inhibition in the hyaluronidase test.—F. James Stubbart, M.D., Orlando; *J. Florida M. A.*, 39:505, January, 1953.

"Sore Throat?" Diphtheria

CARL A. WILZBACH, M. D.

THE World Health Organization concluded a 1952 world report[1] with the statement that "the evolution of the incidence of diphtheria in the coming years can be regarded with optimism."

It is true that great progress has been made here and elsewhere resulting in a drop in the number of cases of diphtheria reported, particularly since the Second World War. In the United States the number fell from 12,405 to 4,743 from 1947 to 1951.

A study of diphtheria in Great Britain[2] includes in its summary the following: "Evidence obtained from this detailed survey of the occurrence of diphtheria among inoculated persons leads to one definite conclusion: Active artificial immunization against diphtheria should be universal. The result would be a marked demonstration accounting almost to elimination of death from the disease.

"Inoculation in the first year of life, followed at the age of six by a single dose of prophylactic and another inoculation at the twelfth to fourteenth year, should induce a sufficient basal immunity to prevent death from the disease in all who are able to react."

A 1952 report on United States Vital Statistics[3] shows that from a three-year period 1929-31, the rate dropped from an average of 60.3 per 100,000 population to a morbidity rate of 2 cases per 100,000 population in 1952.

In Ohio, the incidence fell from a high rate of 36.4 in 1935 to a 1.8 in 1952. Only 2 deaths from diphtheria were reported in Ohio in 1951, while 6 deaths occurred in 1952. Developments in recent months indicate, however, that diphtheria has not been eliminated entirely and that because of its rare occurrence, some physicians need to be reminded and be alerted to this disease possibility.

Dr. John D. Porterfield, Director, Ohio Department of Health,[4] in a statement released from his office March 2, 1953, emphasized the need for continuing intensive immunization programs in Ohio communities. He also called attention to recent deaths from diphtheria and of an investigation of an Ohio school where, over a period of two months, an out-break of "sore throat" had been occurring. When the entire school population was throat-cultured it was discovered that 55 of the children and two of the teachers were carrying virulent diphtheria organisms. While no cases of diphtheria were reported from this school during this period, three deaths in non-immunized preschool children and one severe case of diphtheria in an adult occurred.

Submitted August 7, 1953.

The Author

● Dr. Wilzbach, Cincinnati, is Commissioner of Health, City of Cincinnati Department of Health.

It was suggested that the responsible public health authorities and the private physician talk over this matter and carry out the time-proven immunization procedures. Further, that the physician needs to have a high degree of suspicion in cases of "sore throat," to utilize available laboratory resources, and to report diagnosed cases.

There is the further danger and loss of much valuable time in physicians treating a sore throat with penicillin without trying to make a proper diagnosis by the use of the throat swab.

Diphtheria may involve any part of the respiratory tract, other mucous membranes or the skin. In one series of 273 patients studied, 94.1 per cent were found to have pharyngeal diphtheria.[5]

SYMPTOMS

The symptoms as recorded in the study provide interesting and recent experience and may be more valuable than the usual text book description. The systemic symptoms of early diphtheria were generally mild and insidious in onset. Soreness of the throat was rarely severe at the beginning, but increased gradually to a maximum after several days and often persisted for many days. Headache, muscular aching, malaise, and prostration were not usually severe in the early stages of infection. Fever was often low-grade or absent. Chilliness was noted frequently, but frank chills were uncommon.

The local lesion in the pharynx in its typical form consisted of a grayish, tenacious pseudomembrane, confluent over areas involved, and often extending beyond the tonsillar fossa to the posterior pharyngeal wall. Extension to the soft palate and uvula was frequently observed. Early pseudomembranes appeared translucent and merged almost imperceptibly into the surrounding mucous membrane. Later lesions appeared denser and became more sharply demarcated. Edema of the tissues was often prominent. Erythema was commonly limited to a narrow area around the pseudomembrane. Atypical lesions were common and included follicular or patchy pseudomembranes, pseudomembranes variously colored from greenish to black, complete absence of pseudo-

membrane, and diffuse erythema of mucous membranes.

The manifestations of laryngeal diphtheria were similar to those of other forms of laryngitis. Croupy cough, hoarseness, stridor, and obstructive dyspnea were usually present. Complete aphonia was common. When laryngeal diphtheria was suspected and there was no pharyngeal involvement, visualization of the larynx was carried out to confirm the diagnosis.

Anterior nasal diphtheria was characterized by persistent nasal discharge, often blood-tinged and frequently unilateral. Pseudomembrane was usually visible after removal of secretions.

Cutaneous diphtheria was observed as an ulcerative lesion which did not necessarily have pathognomonic features. Early lesions often consisted of flat bullae partly filled with pus, surrounded by an area of erythema. Late ulcers were only occasionally covered by pseudomembrane and were clinically indistinguishable from other indolent ulcers. Anesthesia of the base of the ulcer occurred in several patients. This symptom was of great diagnostic aid.

COMPLICATIONS

Myocarditis, obstruction of the respiratory tract, and neuritis were the most commonly noted complications of diphtheria, and occurred more frequently in the older age groups, while respiratory obstruction was more common in children. In addition, pneumonia occurred in five patients, nephritis in five, embolism of the femoral artery in one, and general hemorrhagic tendency in one.

Myocarditis occurred in 100 patients (36.6 per cent). The average time of appearance after the onset of infection was 9.8 days; the range was from 2 to 47 days. It appeared on the average earlier (7.2 days) in patients who died then in those who recovered (11.4 days). In many instances of myocarditis of mild degree, electrocardiographic abnormalities were the only manifestation. In more severe cases anginal pain, abdominal pain, syncope, pallor, vomiting, hypotension, arrhythmia of many varieties, deterioration in quality of the apical first heart sound, gallop sound, gallop rhythm, and murmur were noted. Abnormalities as observed electrocardiographically often lasted weeks or months but appeared to be permanent in only one patient. Of 100 patients in whom myocarditis was diagnosed, 36 died.

Severe obstruction of the respiratory tract occurred only in patients who had involvement of the larynx, sometimes in association with diphtheria of the trachea and bronchi. Of 40 patients with severe degrees of obstruction, 26 (65 per cent) died. Atelectasis and pneumonia were also considered to be of obstructive origin.

Neuritis was diagnosed in 44 patients, of whom six (13.6 per cent) died. In 16 patients, cranial nerves as well as nerves of the extremities were involved. Twelve patients had neuritis only in the extremities. Four had glossopharyngeal neuritis only, and in two patients the vagus alone was involved. In ten patients who did not have neuritis of the extremities, the ninth and tenth cranial nerves were both involved. Of the six patients with neuritis who died, four had involvement of the vagus nerve. Intercostal and diaphragmatic paralysis was present in the other two.

Glomerulonephritis was diagnosed in five patients, four of whom died. In the patient who lived, chronic glomerulonephritis with hypertension persisted. It was not certain that this lesion was diphtheritic in origin. Embolism of the femoral artery was observed in one patient and was presumed to result from a mural thrombus complicating diphtheritic myocarditis.

TREATMENT

The success in treating diphtheria depends on the amount of toxin fixed in the tissues, hence the need for prompt administration of antitoxin. Skin tests for sensitivity to horse serum is recommended. Antitoxin can be administered intravenously, diluted in an infusion of 5 per cent glucose solution or normal saline to most patients.

The suggested dose of antitoxin ranges from 10,000 to 100,000 units with 40,000 units more commonly used. If lesions occur in more than one anatomical area, more antitoxin is required. Because the amount of antitoxin to be given is difficult to determine, it is interesting to note what a recent authority has to say about the point.[6]

Since diphtheria is essentially a toxemia with very little invasion of the tissues by the organisms themselves, it appears that prompt recovery should follow administration of the specifically neutralizing antitoxin. The problem, unfortunately, is not quite so simple. Diphtheria toxin in the test tube, it is true, is neutralized promptly, completely and multiple for multiple by antitoxin. Although it can be shown that the toxin is not actually destroyed, the union is a relatively firm one, and dissociation apparently does not occur to a significant degree if the complex is injected into the animal body.

Free toxin, however, when introduced into the circulation evidently attaches itself promptly and firmly to some of the body cells. It is not known whether the ability so to combine with toxin is an attribute of a certain cell type or of some specific component common to various cells. In any event, when this union has taken place, the toxin seems no longer to be subject to neutralization by antitoxin and the train of events which the toxin is capable of initiating continues, even in the presence of a considerable excess of antitoxin in the circulation.

Thus, if a series of animals be injected with similar quantities of diphtheria toxin, the animals being divided into groups, and varying amounts of antitoxin administered immediately to one group,

after five minutes to a second group, and so on, it is found that the amount of antitoxin necessary to save life increases very rapidly with the time interval.

ANTITOXIN NECESSARY TO SAVE LIFE SHOWN BY ANIMAL EXPERIMENT

The following tabulation, cited by Zinsser et al. (1939) shows the amounts of antitoxin necessary to prevent death in rabbits, at various intervals after the administration of ten fatal doses of toxin. It is evident that after a delay of 90 minutes, no amount of antitoxin will save the animals:

Given after 10 minutes, 5 units antitoxin;
After 20 minutes, 200 units antitoxin;
After 30 minutes, 2,000 units antitoxin;
After 45 minutes, 4,000 units antitoxin;
After 60 minutes, 5,000 units antitoxin;
After 90 minutes, no amount.

The exact explanation of the failure of toxin to be neutralized by antitoxin after attachment to the tissues is not yet known. Whatever the ultimate explanation, and, as pointed out in an earlier section, its understanding may well be of great significance, the fact itself supplies the guiding principle which must be applied in antitoxin therapy.

TREATMENT MUST BE PROMPT AND ADEQUATE

The physician seeing a patient whose throat suggests the reasonable probability of diphtheritic infection should send a culture to the laboratory, but should at once administer antitoxin. The laboratory report will later confirm or refute the diagnosis, but far less damage will be done by the administration of an occasional unnecessary dose of antitoxin than by delay in its use when it is required. The following tabulation of fatality according to the day of the disease on which antitoxin was administered is quoted by Russell (1943):

Antitoxin Given on	Cases	Case Fatality
1st day of disease	225	0
2nd day of disease	1,441	4.2
3rd day of disease	1,600	11.1
4th day of disease	1,276	17.3
5th day of disease and upwards	1,645	18.7

No definite rules can be laid down for the amount of antitoxin required for adequate therapy. The actual amount of toxin which has gained entrance to the tissues on the first or second day of the disease is probably small, and could be expressed in terms of a relatively few guinea-pig minimal lethal doses. Were this not so the mortality in untreated diphtheria would be 100 per cent. Since one unit of antitoxin will neutralize (in the test tube) about 30 minimal lethal doses, it might appear that from 100 to 1,000 units would be more than adequate to obtain the desired effect. However, since it is known from experiments such as those previously mentioned, that within limits, increasing the antitoxin will save life, even after contact of the toxin with the tissue, there is a reasonable basis for the current practice of treating diphtheria with relatively large doses of serum.

The objective should be to conteract as much as possible of the injury already done, and to prevent further absorption of toxin. Antitoxin is eliminated slowly, so that a single large dose, raising the blood level as high as possible, will assure the maximum immediate therapeutic effect and provide a level in the blood for many days which will be adequate to cope with further toxin as it is absorbed slowly from the local process in the throat.

Various figures for the recommended unit-age of antitoxin are to be found in the literature. One may perhaps state the general average as suggesting 100 units per pound of body weight in mild cases, up to five times that amount in the severe forms, as adequate therapy. It should be administered in a single dose, intravenously except in the very mild case, where intramuscular injection is satisfactory. Skin tests for sensitivity to the protein of the antitoxin preparation must of course be carried out, and where necessary, desensitization must be undertaken or bovine antitoxin may be employed. In general, it appears that there is little risk of anaphylactic difficulty with the purified and "despeciated" antitoxins now generally available.

Penicillin is commonly given intramuscularly, but there is little evidence that the course of the diphtheria, the incidence or complications are affected. Penicillin does seem to cause the disappearance of the diphtheria organisms in the respiratory tract.

The treatment of laryngeal diphtheria by intubation as formerly taught is a thing of the past and must now be handled by tracheotomy.

In like manner, the old teaching that postdiphtheritic myocarditis should not be treated with digitalis has in recent years been reversed and the drug is given with benefit.[7]

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A Case Record

From The Lutheran Hospital, Cleveland, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Edward Goodsitt, M. D., President

Presented by Richard W. Watts, M.D., and William Sinclair, Jr., M.D.
Edited by William Sinclair, Jr., M.D.

PRESENTATION OF CASE

THIS 42 year old refugee white housewife was admitted to Lutheran Hospital on October 15, 1952, with chief complaints of jaundice of six days' duration and non-radiating, severe, steady, non-colicky, right upper quadrant abdominal pain of four days' duration.

The present illness started with chills, fever and headache with later development of icterus, dark yellow urine, anorexia and lassitude. Bowel movements were regular and yellow. There was no nausea, vomiting, pruritis or history of intolerance to fatty foods. There is a questionable history of two attacks of gallbladder colic three to five years ago in a Displaced Persons camp in Austria. There was no previous episode of jaundice. Nine weeks prior to admission she had some dental work done and received numerous novocaine® injections.

Admission temperature 38 degrees centigrade, respirations 22, pulse 108, blood pressure 96/60. Examination disclosed a well developed, fairly well nourished, coherent, cooperative, walking patient. There was marked icterus of skin and sclerae. Eyes, ears, nose and throat were not remarkable. The heart and lungs were negative. The liver was palpable two finger-breadths below the costal margin and was tender, smooth, firm and the edge was sharp. No other organs or masses were palpable. Pelvic examination showed the cervix to be slightly irregular. The fundus of the uterus was in the upper limits of normal size, smooth and freely movable. The adnexa were not palpable. Rectal examination disclosed clay-colored stool on the gloved examining finger. Neurological examination was negative. No lymph nodes were palpable.

Admission laboratory studies: Red blood cell count, 3.85 million; white blood cell count, 16,550; hemoglobin, 11.6 grams (74 per cent); segmented neutrophils 80, stab forms 14, lymphocytes 5, eosinophils 1; platelet count 272,990; urine, specific gravity 1.010; trace of albumin; no sugar; bile present; negative for urobilinogen. Microscopic studies of urine showed 8 to 10 pus cells, 15 to 20 red blood cells per high power field and frequent, coarsely granular casts and bile-stained sediment. The stool was negative for bilirubin and urobilinogen; blood urea nitrogen, 6 mgm. per 100 cc.; icterus index, 121 units; thymol turbidity, 50 units; cephalin flocculation, 4 plus; alkaline phosphatase, 8.8 units; van den Bergh's test, prompt direct reaction; total serum proteins, 7.2 grams per 100 cc., albumin, 3.4 grams per 100 cc.; globulin, 3.8 grams per 100 cc.; A/G ratio, 0.89; prothrombin time, 30.4 seconds or 19 per cent; blood amylase, 15 units; Kline and venereal disease serological tests, negative; heterophile antibody test, negative.

Many subsequent laboratory studies showed the prothrombin time to be 45.9 seconds on the second hospital day; over one minute on the twelfth hospital day; and over two minutes on the seventeenth hospital day, despite receiving parenteral vitamin K. The icterus index rose to 151 units, and blood urea nitrogen rose to 19.5 mgm. per 100 cc. on the fourteenth day and on the seventeenth day to 33 mgm. per 100 cc. The cephalin flocculation continued to be 4 plus and the thymol turbidity stayed around 45 units. The white blood cell count rose to 20,500, 32,000 and finally on the seventeenth day to 50,150. The red blood cell count ranged from 3.27 to 3.73 million. The urine continued to be positive for bile and negative for urobilinogen; and the stool negative for bile and urobilinogen.

A chest roentgenogram on admission showed the lungs and hilar shadows to be normal. The heart and aorta were also within normal limits. A film of the gallbladder region showed numerous radiant areas which were considered to be due to gas. There was no calcification. The gallbladder shadow was not visible.

The patient's course was relatively afebrile and the highest temperature reached after admission was 37.8 degrees centigrade. The pulse ranged from 75 to 120 and the respirations from 18 to 24. There was progressive increase in clinical icterus and she complained of nausea, weakness, anorexia and lethargy. The liver edge was not palpable on the twelfth day and was not felt any time

later. She developed edema of the hands and legs, became comatose, developed rales over both lung bases, had vaginal bleeding and vomited small amounts of blood. The patient died on the eighteenth hospital day.

CLINICAL DISCUSSION

Dr. Richard W. Watts: The illness described in the protocol may be defined as a rapidly progressive disease involving the biliary system with elements of both obstructive and hepatocellular abnormalities, beginning with chills, fever, and upper right abdominal pain followed by progressive jaundice, edema, coma and death in four weeks. The significantly abnormal laboratory data showed a steadily rising white blood cell count, bile but no urobilinogen in the urine, lack of either bile or urobilinogen in the stool, marked bile retention of the direct van den Bergh reaction type, positive cephalin flocculation and thymol turbidity reactions and markedly depressed prothrombin content despite adequate vitamin K therapy. Relatively normal laboratory examinations included the red blood cell count, blood urea, serum proteins, serum alkaline phosphatase, serological tests for syphilis, serum amylase, and heterophile agglutination.

Since the most obvious feature was that of jaundice it seems appropriate to discuss the case from that standpoint. Jaundice is of three types; obstructive, hemolytic, and hepatocellular. The hemolytic type may be quickly eliminated from discussion since the red blood cell count was relatively constant through the illness.

OBSTRUCTIVE JAUNDICE

The lack in the stool, of either bile or its oxidation product, urobilinogen, which is formed in the intestine, demonstrated obstruction to the flow of bile into the duodenum. The lack of urobilinogen in the urine confirms this impression. Obstruction can be purely mechanical due to common duct stone or to carcinoma arising in the bile ducts or ampulla of Vater, or metastatic from pancreas, stomach or other organs.

Obstructive jaundice may be simulated by ascending cholangitis in which there may not be complete obstruction but rather a change in permeability of the bile duct membranes due to infection. Also infectious hepatitis may mimic obstructive jaundice, especially in its early stages, when the intercellular bile canaliculi are inflamed with resultant obstruction and rupture. Although this occurs in the liver lobules it acts like obstructive jaundice.

There is a suggestive past history here favoring gallbladder disease so that common duct stone is a possibility. However, a four week illness ending in death would be unusually rapid for a common duct stone. The same is true of carcinoma. In addition, no mass was noted by examination or by roentgenograms and this also speaks against carcinoma. Ascending cholangitis is characterized by intermittent fever and fever was absent in this case except in its onset so that this diagnosis would be tenuous.

HEPATOCELLULAR JAUNDICE

There is overwhelming evidence of hepatocellular involvement in this case. Not only are the cephalin flocculation and thymol turbidity reactions positive but there is a consistent hypoprothrombinemia despite adequate vitamin K. The latter may be due to poor intestinal absorption of vitamin K but when it is given parenterally, as in this case, then the lack of prothrombin formation most probably is due to hepatic dysfunction. The terminal bleeding and coma are also the results of severe hepatocellular dysfunction.

Among the causes of hepatocellular jaundice must be mentioned Weil's disease or leptospirosis; toxic hepatitis following exposure to carbon tetrachloride, chloroform, phosphorus, or cinchophen; and the cirrhoses such as Laënnec's, post-necrotic, and obstructive biliary cirrhosis. The various cirrhoses may be ruled out by the lack of any appreciable hepatosplenomegaly; in fact, decreasing size of the liver is suggested. Also all the clinical features of this patient point to an acute rather than to a chronic process and while many chronic illnesses may have acute onsets or exacerbations this seems too fulminating to merit such a diagnosis.

This brings us to the more acute infections of the liver. Bacterial involvement such as hepatic abscess from an appendiceal abscess is ruled out by lack of fever. Leptospirosis merits consideration in view of the fulminating course. This disease usually is acquired via infected rat urine and therefore usually affects ditch diggers, sewer workers, miners, etc. It is rare in women with about 5 per cent of cases reported in females. The onset is marked by high fever and myalgia followed in a few days by signs of hepatic and renal involvement as well as hemorrhagic phenomena due to capillary involvement rather than hypoprothrombinemia. Leukocytosis may occur to a great degree. Thus this case varies from the usual case of leptospirosis in that fever was not marked, it occurred in a woman, and there was no myalgia or significant renal involvement. Infectious mononucleosis may cause hepatitis but the negative heterophile agglutination test rules out this diagnosis.

Hepatic poisons could well cause the progressive course seen here. The lack of history of ingestion is a great deterrent to the diagnosis. Carbon tetrachloride, like leptospirosis, affects both liver and kidneys. Phosphorus causes severe vomiting when taken by mouth and chloroform and cinchophen are rarely encountered at the present time.

INFECTIOUS HEPATITIS

This brings us then to infectious hepatitis. Two types have been described. Both serum

hepatitis (homologous serum jaundice) and infectious hepatitis are due to a virus and while these two conditions are indistinguishable clinically, laboratory study has shown differences in the two vira. The virus of infectious hepatitis has been found in the blood and stool of the patient while that of serum hepatitis is found only in the blood where it may persist for many months. Thus the mode of transmission of infectious hepatitis is fecal while serum hepatitis can be transmitted only by contact with blood or blood products, that is, in the use of plasma or from contaminated needles or syringes used in inoculations and blood tests. The incubation period of infectious hepatitis is 15 to 40 days while that of serum hepatitis varies from 60 to 120 days. Immunity to one virus does not imply immunity to the other.

While infectious hepatitis has a remarkably low mortality rate, well under 1 per cent in most epidemics, nevertheless it may end fatally. This is more likely to occur in women, especially during pregnancy or over the age of 40. In fatal cases the course is rapid with hepatic coma, bleeding and ascites. The latter event usually does not occur unless the process goes on for over 30 days. Despite the massive necrosis in the liver there is usually little fever or leukocytosis.

Thus in most features, this case resembles fatal infectious hepatitis. Whether it was of serum origin cannot be decided. The only inoculations were those of novocaine® eight weeks before onset. This would give an incubation period of 56 days, which is rather short for serum hepatitis. The obstructive feature of the jaundice can be explained by the intralobular, intercellular, canalicular blockage seen in infectious hepatitis. The hepatocellular jaundice, so well shown in the chemical tests and the lack of response to vitamin K, can be explained by massive necrosis of the liver. One disturbing feature in this case is the rising white blood cell count. The only counterpart I can find to it is a case described by Lucke[1] in 1944 in which the white blood cell count rose to 31,000. However, if we adhere to the definition of this illness as stated at the beginning of the discussion, I believe fatal acute infectious hepatitis must be the diagnosis.

Clinical Diagnosis: Infectious hepatitis.

Dr. Watts's Diagnosis: Infectious hepatitis.

Pathological Diagnosis: (1) Infectious hepatitis; (2) Cholemic nephrosis; (3) Bronchopneumonia; (4) Ascites, 700 cc.

PATHOLOGICAL DISCUSSION

Dr. William Sinclair, Jr.: The changes in the liver were typical of infectious hepatitis, the essential features of which were as follows:

The liver weighed 900 grams (normal 1400-1600 grams), was small, soft, friable and flabby. The capsule was wrinkled, glistening and slightly translucent. There were prominent widespread, slightly bulging, subcapsular, yellow and reddish-brown zones throughout the liver, most marked in the right lobe. The transected surfaces of the liver disclosed soft, friable parenchyma in which were abundant focal, diffuse and confluent foci of bulging, yellow, mottled red tissue. At the margins these regions were sharply defined from



Fig. I. Gross photograph of liver. Note sharply defined zone of necrosis.



Fig. 2. Liver lobule showing complete necrosis of parenchymal cells with preservation of lobular outline. Note fairly well preserved ducts in periportal regions. 50 X

the adjacent dark reddish brown parenchyma. (See Fig. 1.) The gross appearance was typical of so-called acute yellow atrophy.

MICROSCOPIC STUDY

The liver was the seat of massive, diffuse necrosis of central, midzone and peripheral portions of the lobules in many regions. The outlines of the lobules were preserved. (See Fig. 2.) Various stages of degeneration and necrosis were present in different portions of the liver and sometimes only focal zonal necrosis was present. In some regions the parenchymal cells showed disassociation and loss of normal cord-like and lobular arrangement. These cells were frequently large, hyperplastic, atypical in shape and staining reaction and occasionally were multinucleated. These foci were interpreted as early regeneration. In some sections there was slight infiltration of stroma with lymphocytes, neutrophils and

plasma cells. The inflammatory exudate was not a prominent feature.

The bile ducts in the periportal spaces were prominent, well preserved, generally empty and showed no bile stasis. These ducts appeared increased in number, although this is interpreted as more apparent than real due to the reduced size of the lobules and liver. The small intralobular and intercellular bile canaliculi were plugged frequently with masses of bile and this is considered to be the basis of the severe obstructive type of jaundice as indicated by the laboratory determinations. (Fig. 3.) The combination of hepatocellular damage and intralobular obstructive processes explain the various alterations in liver function tests as discussed by Dr. Watts.

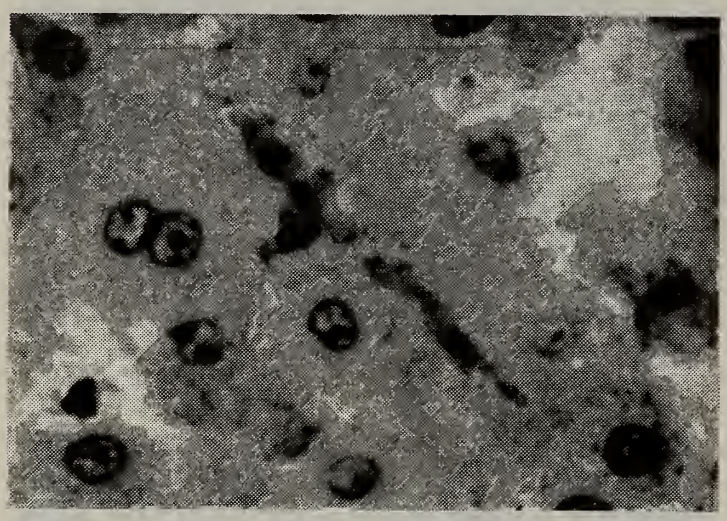


Fig. 3. Liver. Intralobular, intercellular, canalicular bile stasis. 360 X

The gallbladder was filled with thick, viscid, tenacious, green bile. There were no calculi present. The extrahepatic bile ducts were of average size, were patent throughout and no calculi were present. There was no bile-staining of the linings and this correlates well with the absence of bile in the stool and urobilinogen in the urine as bile was not getting into the extrahepatic ducts or the intestine due to intrahepatic obstruction.

The common bile duct contained small amounts of clear, slightly viscid, tenacious fluid. This type of reaction was the basis of a former designation for infectious hepatitis, namely catarrhal jaundice. Nearly a century ago Virchow described catarrh and mucous plugs in the bile ducts and considered these plugs to be the etiologic factor. It is now known that the primary disease is in the liver in the form of hepatitis of viral origin. This was established about ten years ago when the disease was prevalent in the armed forces.

The kidneys showed marked cholemic nephrosis. There were bile casts in the lumens of the convoluted and collecting tubules and the lining cells of the convoluted tubules were swollen and had granular cytoplasm. The nuclei were frequently absent. The relatively low blood urea nitrogen (6 mgm. per 100 cc.) is explained on the basis of the severe acute liver damage and the gradual rise is interpreted as resulting from renal damage and failure due to progressive cholemic nephrosis. The kidneys were unable to remove even the small amounts of urea formed.

Of interest was the presence of ascites (700 cc.). This fluid was bile stained. The mechanism of formation of ascites is not entirely clear. Ascites has been described frequently in infectious hepatitis.

The lungs were the seat of bronchopneumonia which is considered a terminal event.

There were subepicardial and subendocardial petechiae in the heart and petechiae were observed beneath the visceral pleura. These hemorrhagic foci are correlated with the low prothrombin time which is due to reduced prothrombin content of the blood resulting from decreased formation on the basis of liver destruction.

The uterus was enlarged to a size consistent with a 2½ months pregnancy and contained decidua. There was no fetus and no chorionic villi were observed. This was a surprise at autopsy as there was no mention of this made in the history. As Dr. Watts has stated, fatalities are slightly more frequent in pregnant than non-pregnant patients. The reason is not clear. Miscarriages are frequent.

GENERAL DISCUSSION

DR. S. C. LIND: Years ago we saw cases of this type of hepatic necrosis and called them acute yellow atrophy. What is the relationship of acute yellow atrophy of the liver to infectious hepatitis?

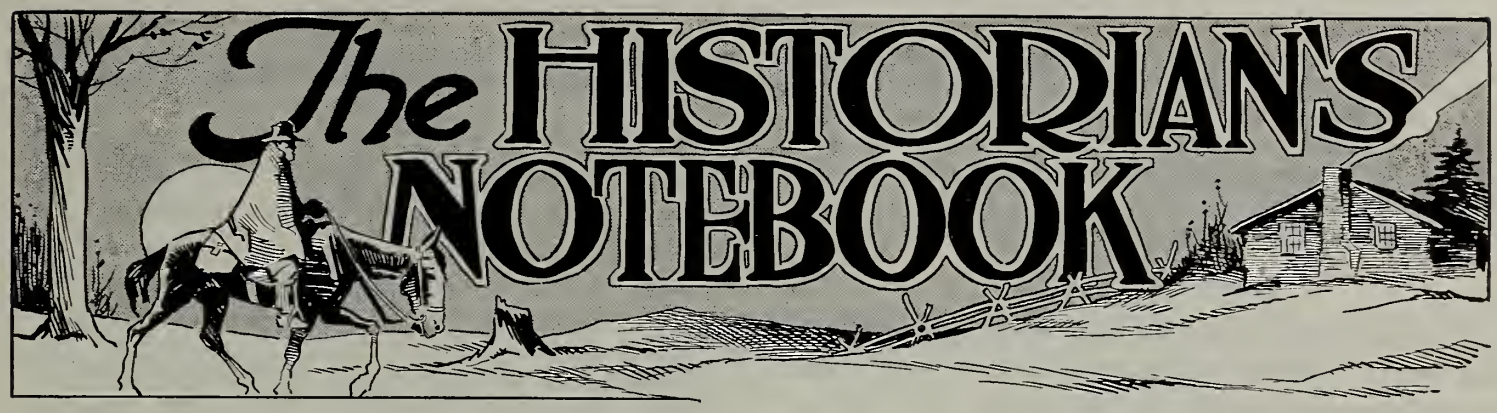
DR. W. SINCLAIR: It is apparent that many instances of so-called acute yellow atrophy in the past were actually fulminating infectious viral hepatitis. Acute yellow atrophy is a general, descriptive term for severe, rapidly progressive necrosis and degeneration of the liver due to a variety of causes including toxic drugs and chemical substances. Infectious hepatitis is one of the agents and was only clearly recognized as such during the last war.

DR. MYRON AUGUST: Do you consider this infectious hepatitis rather than homologous serum jaundice?

DR. W. SINCLAIR: Yes. The incubation period is rather short (about 56 days) for homologous serum jaundice, assuming the dental injection was the method of contamination. I doubt if the dental work had anything to do with the hepatitis in this case. Virus studies were not performed and this would be the only certain way to distinguish the viruses. The morphologic changes in the liver in fatal cases in both conditions are, for all purposes, indistinguishable from one another at the present stage of our knowledge.

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Introduction of Insulin to Columbus

CHARLES W. McGAVRAN, M.D., and JAMES H. WARREN, M.D.

THE management of diabetes has been divided into various periods, depending upon the type of dietary treatment. The great division should be, pre-insulin and post-insulin eras. In the early twenties we were trying to control diabetes by a very low carbohydrate, high protein and low calorie diet. The carbohydrates would often be kept as low as 15 grams a day. These patients would lose weight and would be in a chronic state of acidosis. Many would slip into coma and die. Juvenile diabetes meant certain death in a very short period of time.

In December of 1921 a paper was presented before the American Physiological Society by Banting, Best and Macleod on the "Internal Secretion of the Pancreas." The investigation had been made by Banting and Best in Professor Macleod's laboratory at Toronto during the summer of 1921. The results had been presented to the faculty that fall.

INSULIN INTRODUCED

As a result of this work, methods of production of insulin were perfected and Iletin® (Lilly & Co.) was put into production. At first the supply was for experimental studies.

About the middle of December, 1922, Dr. J. J. R. Macleod of Toronto presented a paper before the Chemical Society at Ohio State University. He visited our office and after looking over our records and charts volunteered to have an experimental supply of insulin sent to Columbus. It was in January 1923, that the first shipment was received. Some of this was allocated to other physicians of the community, one of them being Dr. Howard Brundage.

The medical department of Grant Hospital was then located on Town Street. It was there the insulin was first used on a few selected patients. Iletin® was made in two strengths, U-10 and U-20. A few bottles were received about every five days. Dosages were small compared with what we use today. The cost was great compared with today as later on insulin was supplied through local drug companies upon prescription.

Submitted September 1, 1953.

The Authors

- Dr. McGavran, Columbus, senior physician, Grant Hospital.
- Dr. Warren, Columbus, senior physician, Grant Hospital.

The results obtained from some of the first patients receiving insulin were reported to Dr. Macleod as follows:

January 26, 1923

Dr. J. J. R. Macleod
Toronto University
Toronto, Canada

My dear Dr. Macleod:

We are having some very interesting work and some very satisfactory results in the use of Iletin.®

Our man, McLean, who could not tolerate 1400 calories went into the hospital with a blood sugar of 300 mgs. and four plus acetone with a small amount of sugar in his urine. He was given 20 units of Iletin® on January 15 and on the next day his blood sugar was 160 mgs. Sugar had disappeared from the urine and there was less acetone. Since that time the calories have been gradually increased until he is today taking over 1900. He is sugar free and acetone free. He is now getting 10 units a day.

One little girl, age 6, was brought to Grant Hospital just on the verge of coma, alveolar tension 10. She was given Iletin,® orange juice and water. She has shown a very marked improvement and today is sugar free and has just a trace of acetone.

One little woman, reduced from 120 to 62 pounds on whom a carbohydrate tolerance of 19, protein 35, fat 140, with a total caloric value of 1476 was established, has been placed on Iletin,® giving her increased glucose tolerance.

We are keeping accurate records on every

case which we will be glad to furnish you. We are having some pictures taken of the charts that you saw on the walls, after they are completed, will have some prints made and send you some of them. It is our desire to be right in the management of these cases and we will be glad to carry out any line of investigation that you might suggest.

THE FIRST CASES

The man McLean, mentioned in the above letter, had been a diabetic for three years and had gone down from 206 pounds to 96 pounds and was in a chronic state of acidosis. He received the first dose of insulin in Columbus. The improvement was steady and he was able to carry on as a dentist and finally 20 years later died as a result of gangrene of the lower extremity.

Many of the first patients receiving insulin have died from arteriosclerosis in one form or another. One of the early patients died of pulmonary tuberculosis, another from cancer of the breast.

One of the first to receive insulin was a baby 18 months old. He is still alive, taking 60 to 75 units of insulin a day. He has a family of three children and shows no definite deleterious changes. Insulin has permitted juvenile diabetics to live.

Today the treatment has improved with the advent of the various modified forms of long acting insulin. More liberal diets are allowed, patients are living longer and very seldom does one see a diabetic in coma. Arteriosclerosis is the big problem.

As the supply of insulin was increased and preliminary studies had demonstrated its safety and value, it became available through the druggist. There was a change in the mode of treatment. The diabetic patient was allowed more carbohydrate yet restricted far below the amount now prevalent in today's diet. We were among the first to advocate what then seemed to be excessive amounts of carbohydrate. For instance, 150 grams daily when the larger and well known clinics were treating patients with a third of that amount. This idea was presented before the Columbus Academy of Medicine.

With the advent of insulin, coma in diabetics began to diminish and many of these patients could be saved. We have followed many of the cases that received insulin in its early days.

It is only the physician who was in active practice before 1922 who can realize to the full extent what insulin has done, is doing and will do for the diabetic patient.

Khellin is the active principle of Ammi visnaga, an Egyptian plant which has been used for many decades for the treatment of ureteral colic.—M. R. Hejtmancik, M. D., *Texas State J. M.*, 49:679, Sept., 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Gomphosis—Coming from the Greek word "gomphos" meaning a nail or bolt this term literally means nailed or bolted together. Anatomically this term is used to denote a form of joint in which a conical body is fastened into a socket as the teeth into the jaw.

Gumma—Coming from the Latin word "gummi" or gum, this term is said to have been descriptively applied in 1530 by Fracastorius to a specific lesion of late or tertiary syphilis. This lesion was so called because it is a fibrous-like mass with a gelatinous necrotic center having the elastic consistency of firm rubber or gum.

Gravid—This rather obsolete term, literally means to be heavy with child and is derived from the Latin word "gravis" or heavy.

Groggy—This term meaning "unsteady" has a curious origin and it originally meant being drunk from "grog" which is an English sailor's drink. Grog in turn is a derisive nickname which was applied to rum diluted with water. In 1740 Admiral Edward Vernon of the Britsh Navy ordered that all rations of rum issued to the sailors be diluted with water. The admiral was called "Old Grog" by his sailors because he habitually wore a "grogram cloak," which was a garment made of a coarse grained cloth known as "grogram," this term being derived from the French "gros" or coarse, plus grain.

Gut-Guts—Now used as a semi-vulgar term designating the intestines, this word comes from the Anglo-Saxon word "guttas" meaning a channel or a ditch and this in turn comes from the Anglo-Saxon word "geotan" meaning to pour. The word "gut" is not, as is commonly believed, related to the Latin word "gutta" meaning a drop. However, both the Latin "gutta" and the Anglo-Saxon "geotan" both stem from the Aryan root "ghud" meaning to pour.

Inebriate — When a man is inebriated or drunken, we frequently say that he is "in his cups." This is the literal meaning of this term which is composed of the Latin "in" or into, plus the Latin "ebrius" or drunk, which derives from the Latin "e" or beyond and "bria" or cup. Hence the drunk is literally "in beyond his cups."

Orchitis—Literally meaning an inflammation of the testicle this term is derived from the Greek words "orchis" or testicle, plus "itis" or inflammation of. The term "orchis" as a name for the testicle is of ancient usage. Inflammation of the testicles was noted by Celsus, however the term "orchitis" itself is fairly recent and came into use in about the 18th Century.

—HARRY WAIN, M. D., Mansfield, Ohio.

Proceedings of The Council . . .

Heavy Docket Considered At Fall Conference in Granville; Schedule For 1954 Annual Meeting Approved; Reports on Other Activities Received

THE annual Fall conference of The Council of the Ohio State Medical Association with committee chairmen and A. M. A. delegates was held at the Granville Inn, Granville, Ohio, October 2, 3 and 4, 1953. Those attending were: President Davis; President-Elect Prugh; Past-President Clodfelter; Treasurer Meiling; Councilors Heusinkveld, Woodhouse, Jarvis, Orr, Hudson, Gustafson, Foster, Martin, Pitcher, Artman, and Hattery; A. M. A. Delegates Brindley, Sherburne, Skipp, Wright and Lincke; Dr. A. Carlton Ernstene, Cleveland, chairman of the Committee on Scientific Work; Dr. Drew L. Davies, Columbus, chairman of the Military Advisory Committee; Dr. E. J. Wenaas, Youngstown, chairman of the Judicial and Professional Relations Committee; Dr. H. P. Worstell, Columbus, chairman of the Committee on Industrial Health and Workmen's Compensation; Dr. E. K. Yantes, Wilmington, chairman of the Committee on Rural Health; Dr. Jonathan Forman, Columbus, Editor of *The Journal*; Mr. Wayne E. Stichter, Toledo, legal counsel for the Association; and Messrs. Nelson, Saville, Page and Moore.

The minutes of meetings of The Council held on July 11 and 12, 1953, were **approved.**

MEMBERSHIP STATISTICS

The Executive Secretary presented the following report on membership: Total State Association members as of October 1, 1953, 7,930; compared to a total membership of 7,806 as of December 31, 1952. The breakdown of the total membership was as follows; Dues-paying members, 7,598; members on military waiver, 180; members whose dues were waived because of retirement through age or disability, 152.

The report also presented the following data regarding A. M. A. membership: Number of Ohio members certified to the A. M. A. for 1953 membership, 6,830. The breakdown on A. M. A. members was as follows: Dues-paying members, 6,315; members through military waiver, 150; members through exemption of dues because of age or retirement, 365.

1954 ANNUAL MEETING

Dr. A. Carlton Ernstene, Cleveland, chairman of the Committee on Scientific Work, and the Executive Secretary presented a report on the plans and arrangements, to date, for the 1954 Annual Meeting to be held April 12, 13, 14, 15 in Columbus.

The schedule for Annual Meeting events presented by the committee and approved by official action will be found on page 1018.

CONFERENCE OF LOCAL OFFICERS

It was suggested that the Annual Conference for Presidents, Secretaries and Committee Chairmen of County Medical Societies, to be held on Tuesday, April 14, consist primarily of panel discussions by local officers or committeemen on such subjects as handling of grievances, public relations program by small county medical societies with limited budgets, why a community health council, etc. This idea was approved by The Council.

The Executive Secretary was requested to contact the Ohio Academy of General Practice to see if it would give credit to its members attending the Annual Meeting program and, if so, that this information be carried in Annual Meeting publicity.

COMMITTEE ON PUBLIC RELATIONS REPORT

Dr. H. B. Wright, Cleveland, and the Executive Secretary presented a report on the meeting of the Committee on Public Relations and Economics held in the Columbus office on Sunday, September 20. On motion duly made, seconded and carried, the report was adopted.

PUBLIC ASSISTANCE PROBLEMS

The report pointed out that many phases of Ohio's public assistance program and aid for the aged program were reviewed and that the Executive Secretary has been instructed to compile a report based on the committee's discussion for consideration of the committee at a later date.

Dr. Wright also stated that the committee felt there should be a conference with officials of the state welfare department and state health department relative to present laws and policies on facilities for the mentally and chronically ill; proposals and plans for expansion of such facilities; regulations regarding admissions to state facilities, etc. The committee, he said, requested the committee on Chronic Illness, Committee on Mental Hygiene and Cancer Committee to meet with the state officials in the near future to discuss these matters.

V. A. MEDICAL PROGRAM

Another portion of the report of the Committee on Public Relations and Economics related to the medical and hospital programs of the Veterans Administration. The policies of the Ohio State Medical Association on this question were re-

viewed by Dr. Wright and the Executive Secretary. Reference was made to meetings on this subject held in Chicago on September 1 and September 15, which were attended by representatives of the Ohio State Medical Association. Actions taken by the Committee on Public Relations and Economics were approved by The Council, which included endorsement of the recommendations made by the Advisory Committee to the Public Relations Department of the A. M. A. on ways to implement the A. M. A. policy which had been adopted last June by the House of Delegates of the A. M. A., opposing care of veterans with non-service-connected disabilities by the Veterans Administration.

President Davis informed The Council that the Veterans Administration has not as yet acted on suggested changes in its fee schedule in effect in Ohio as recommended by the Association almost a year ago. He stated that the agreement with the V.A., effective July 1, 1953, had been signed by him with the understanding that the V.A. would act on the fee schedule matter promptly. The Council instructed the Executive Secretary to write the V.A. in Washington again on this matter.

By official action, The Council instructed the Executive Secretary to endeavor to secure authentic information regarding the extent of the Ohio program for the medical care of veterans, number of veterans being treated, number of physicians participating, costs of program, etc.

WORKMEN'S COMPENSATION

Dr. H. P. Worstell, Columbus, chairman of the Committee on Industrial Health and Workmen's Compensation, advised The Council that, to date, no action had been taken by the State Industrial Commission on the recommendations submitted by the Association for changes in the Medical and Surgical Fee schedule. Dr. Worstell reported that he had had several personal conferences with representatives of the Commission and that it had been indicated that the Commission might take some action, or request a conference on this matter, within the next several weeks. The Council decided to delay follow-up action temporarily, pending word from the Commission as to when it desired to confer with representatives of the Association on the recommendations.

A letter inquiring if it would be discreet for a physician to charge a Workmen's Compensation claimant who carries medical and surgical insurance, a fee higher than the fee allowed by the industrial commission was considered. The Council by official action held that physicians should not follow that procedure.

MILITARY SITUATION

Dr. Drew L. Davies, Columbus, chairman of the Military Advisory Committee, reported that his committee had been advised by the national committee that in all probability no additional physicians would be inducted for military service during the next year. Dr. Davies referred to the article in the October issue of *The Ohio State Medical Journal* on this question. He stated that the activities in the Columbus office were now being concentrated on bringing biographical and professional files up to date and assisting Selective Service in the classification of physicians in event induction of physicians should be resumed sometime next year. Dr. Davies also referred to the close cooperation between his committee and the Physicians' Placement Service of the State Association.

MEDICAL EDUCATION CAMPAIGN

Mr. George H. Saville, Director of Public Relations, and Dr. Wm. M. Skipp, Youngstown, advised The Council that the 1953 Ohio campaign for contributions to the American Medical Education Foundation would be launched within the next several weeks. They reported that a letter would be sent in the near future to all members, outlining the campaign and requesting contributions, and that campaign literature and instructions would be sent to all county chairmen. Members of The Council were reminded that they constitute the state campaign committee and were urged to stimulate action in all counties in their districts. Mr. Saville referred to the article published in the October issue of *The Journal* which carried statistics on the number of Ohio physicians making contributions in 1952, and other information on this project. He emphasized that physicians who had been making contributions to their own schools should be encouraged to do so and that donations made through the Foundation could be earmarked for a particular school by the donor. Mr. Saville stated that he had been advised by the Foundation that two distinguished service awards involving Ohio had been made, namely, to the Butler County Medical Society and to the F. M. Douglass Foundation, Toledo, both of which had made substantial contributions to the Foundation in 1952.

FIFTY YEAR AWARDS

The question of 1953 Fifty-Year Awards was discussed. The Executive Secretary advised members of The Council that certificates and emblems had been forwarded to them, and members of The Council were requested to contact county societies in their districts promptly regarding the presentations.

A letter from the Summit County Medical Society, stating that the council of that society recommended that certificates and emblems be presented to physicians who have engaged in the practice of medicine for 35 years, was considered. By official action, The Council expressed itself as believing that the present program should be continued, namely, of presenting certificates and



Members of The Council with A. M. A. delegates, certain committee chairmen and other key persons in the Association are shown above as they met in Granville.

Left to right, seated: Drs. Brindley, Meiling, Clodfelter, Davis, Lincke, Prugh, Skipp and Orr.

In the same order, standing: Drs. Forman, Gustafson, Worstell, Martin, Sherburne, Ernstene, Heusinkveld, Wright, Mr. Nelson, Drs. Hudson, Jarvis, Artman, Foster, Pitcher, Hattery, Mr. Stichter, Mr. Saville and Dr. Woodhouse.

(O.S.M.A. Staff Photo)

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emblems to physicians on the 50th anniversary of their graduation from medical school.

HOSPITAL INSURANCE QUESTION

Dr. E. H. Artman, Chillicothe, Councilor of the Tenth District, reported that he had succeeded in arranging a conference between representatives of Central Hospital Service and representatives of the Central Ohio Psychiatric Society to discuss problems which had developed because Central Hospital Service does not provide hospitalization benefits for persons hospitalized for mental ailments. He stated that no solution of the problem had as yet been worked out, but that the recommendations of the Psychiatric Society had been taken under consideration by Central Hospital Service.

OHIO MEDICAL INDEMNITY

The Executive Secretary submitted a report with regard to various activities of Ohio Medical Indemnity, Inc. Copies of the new preferred contract of O. M. I. and a memorandum from Mr. Coghlan, Executive Vice-President of O. M. I., regarding the preferred contract were distributed to members of The Council.

A specially prepared handbook, reviewing in detail the activities of O. M. I. and including statistics on claims, subscribers and finances was given to each member of The Council.

The Executive Secretary reported that O. M. I. is planning the production of a series of educational pamphlets to be distributed to physicians of Ohio and that an effort will be made by *The Ohio State Medical Journal* to carry news items monthly regarding O. M. I.

Also, The Council was advised that plans had been completed by O. M. I. for the construction of a new home office building in suburban north Columbus. This action was taken by the Board of Directors of O. M. I. when adequate office space at a reasonable rental could not be secured in downtown Columbus.

HOSPITAL ACCREDITATION

Correspondence relating to problems which had arisen in Ohio under the new hospital accreditation program of the A. M. A. and other national groups was presented. Certain members of The Council also reported on problems which had arisen in their communities. It was the feeling of The Council that the policies and principles established for the accreditation of hospitals were too stringent in the case of certain small hospitals. In order to secure factual information on the situation throughout Ohio and to prepare a report which would offer constructive suggestions to the Commission on Accreditation, The Council, by official action, authorized the President to appoint a committee of three Councilors to investigate this question. Following the adoption of that motion, Dr. Davis appointed the following committee: Dr. George A. Woodhouse, Pleasant Hill, chairman; Dr. Paul F. Orr, Perrysburg, and Dr. Robert S. Martin, Zanesville.

WILSON CASE

Mr. Stichter informed The Council of certain delays which had occurred in the filing of briefs in the appeal of Dr. Harold J. Wilson, Columbus, from the action of the Columbus Academy of Medicine in expelling him from membership. He

recommended that in view of this complication the date for the hearing of Dr. Wilson's appeal be postponed and that a suitable future date be set.

CASE REFERRED TO COUNSEL

The Council considered a request from the Toledo Academy of Medicine that it study court opinions in a Toledo malpractice case in which opinions certain general principles with respect to the responsibility of physicians were enumerated. Representatives of the Toledo Academy of Medicine felt that perhaps the State Association should enter the case as a friend of the court and file briefs. On **motion** duly made, seconded and unanimously **carried,** the matter was referred to Mr. Stichter for review and for his recommendations as to whether the Association should or should not enter the case.

RURAL HEALTH ACTIVITIES

Dr. E. K. Yantes, Wilmington, presented a brief report on the activities and plans of the Committee on Rural Health. He referred particularly to plans which are being made for the lectures on general practice in a small community to be presented next Spring; the rural medical scholarship; cooperation with the 4-H groups of Ohio with respect to physical examinations for contestants for the healthiest boy or girl; and the study being given to the question of rural externships for senior medical students. Particular emphasis was made to the public relations value of physicians and county medical societies cooperating with the 4-H groups on their health activities.

P. G. COURSES IN NINTH DISTRICT

A letter from Dr. Herbert D. Chamberlain, McArthur, was read and a supplemental report presented by Dr. Pitcher, Councilor of the Ninth District, proposing postgraduate courses for physicians in the Ninth District.

It was the opinion of the Council that the State Association and Dr. Pitcher should cooperate with Dr. Chamberlain on this matter and that arrangements should be made as soon as possible for a series of postgraduate lectures in that district.

SCHOOL HEALTH COMMITTEE PLANS

Mr. Page, Secretary of the Committee on School Health, reported on plans and activities of that committee. He stated that the committee is planning to produce in the near future several more pamphlets to be a part of a series of pamphlets sponsored by that committee. Mr. Page also reported on plans which are being made for an Ohio conference on physicians and schools to be held next Spring in Columbus with a number of other statewide health agencies and organizations. Brief comments were made by Mr. Page regarding the National Conference on Physicians and Schools sponsored by the A. M. A. which had been held this week in Chicago and which he and Dr. Carl A. Wilzbach, Cincinnati, had attended as official representatives of the Association. Mr. Page also advised The Council of the cooperation which the committee and the Columbus office are giving to various local school health conferences and referred particularly to the excellent conference held recently in Tuscarawas County.

OTHER COMMITTEE ACTIVITIES

The Executive Secretary reported that the special Subcommittee on Interprofessional Relations on Eye Care had held a number of meetings and that the committee is preparing a report to be reviewed by the Committee on Public Relations and Economics at a later date. He reported also that the Committee on Maternal Deaths was planning to meet in the near future.

ROSS COUNTY AMENDMENTS

A communication from the Ross County Academy of Medicine, advising that the society on September 24, 1953, had adopted certain amendments to its constitution and by-laws relating to classes of members, was discussed. By official action The Council approved the amendments.

STATE BALLOT ISSUES APPROVED

The Executive Secretary and the Director of Public Relations reviewed for the information of The Council the two proposed amendments to the Ohio Constitution which will be voted on November 3, namely, the proposal for a $500,000,000 revenue bond issue for road improvements and a proposal to create a State Board of Education. After considerable discussion, on **motion** duly made, seconded and **carried,** The Council endorsed both proposals and instructed the Executive Secretary to advise the membership accordingly.

WOMAN'S AUXILIARY

A letter from Mrs. N. M. Reiff, Washington Court House, President of the Woman's Auxiliary of the State Association, stating that the Auxiliary had been very successful in securing advertising for the September issue of the *Ohio Medical Auxiliary News* and requesting The Council to approve solicitation of advertising for future issues, was discussed. By official action, The Council congratulated the Auxiliary on the success of its advertising program and approved solicitation of advertising for issues of the Auxiliary bulletin between now and the Annual Meeting next Spring.

A request from the Woman's Auxiliary, that The Council approve active interest by the Auxiliary in the formation of future nurses' clubs in the high schools, was considered. It was explained that the purpose of these clubs is to stimulate interest on the part of high school students in making nursing a career and that these clubs are now functioning successfully in a number of states—notably Michigan and

Maryland. By official action, The Council approved this request.

SPECIAL COMMITTEE BY RADIOLOGISTS

A letter from Dr. Austin J. Brogan, Dayton, President of the Ohio State Radiological Society, stating that the Radiological Society had formed a special committee on hospital-physician relationships, was considered. Dr. Brogan's letter pointed out that the Radiological Society requested the approval of The Council of the State Association and that the committee would maintain close liaison with county medical societies and the State Association on its activities. The Council adopted a motion complimenting the Radiological Society on this action and extending the cooperation of the State Association.

REHABILITATION QUESTION

The Council was advised that in all probability a resolution would be presented to the A. M. A. House of Delegates in December requesting the elimination of the word "rehabilitation" in connection with the title of the A. M. A. Section on Physical Medicine and Rehabilitation and in connection with the title of the A. M. A. Council on Physical Medicine and Rehabilitation. It was pointed out that the use of the word "rehabilitation" in those connections indicated that only physicians specializing in physical medicine are interested in rehabilitation activities, whereas all members of the medical profession are to some degree or other interested in this activity. Members of The Council individually expressed their opinion that the elimination of the term "rehabilitation" in connection with the titles of the section and the council would be desirable. However, no official action was taken, inasmuch as the resolution which probably will be presented was not before The Council in final form. Ohio delegates were advised to use their own judgment, keeping in mind the unofficial views expressed by members of The Council.

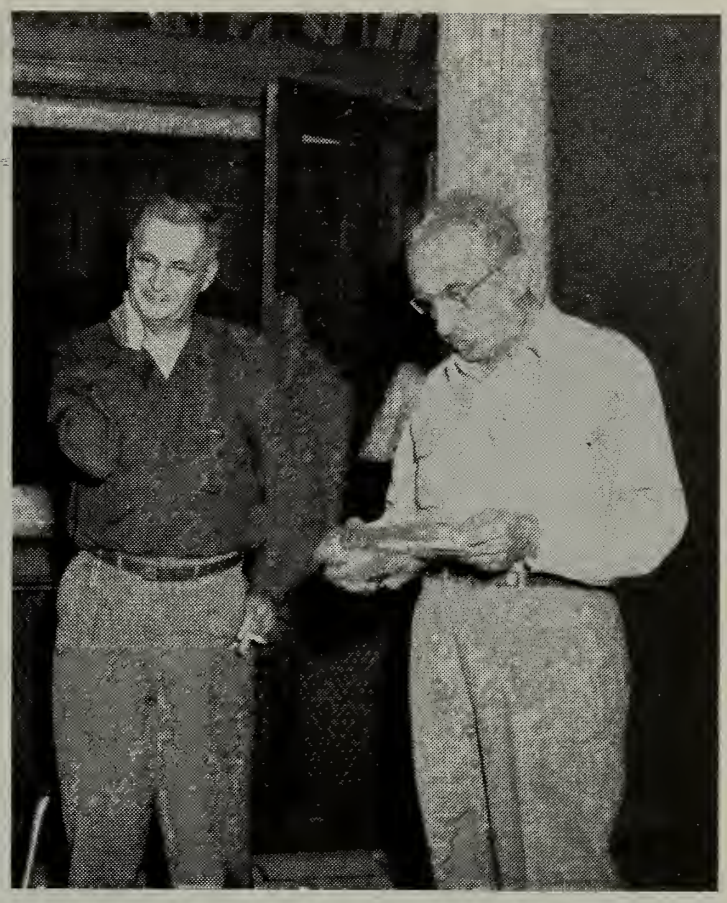
GRIEVANCES DISCUSSED

The President then called on members of The Council to report on meetings, activities and grievances involving their County Medical Societies. Verbal reports were presented by all members of The Council. While discussing grievance problems, The Council adopted a motion requesting the Executive Secretary to prepare a detailed memorandum on procedure which should be followed by members of The Council and by County Medical Societies in handling grievance cases, and to submit the memorandum to The Council at its next meeting for consideration and action.

EXECUTIVE SECRETARY FELICITATED

Prior to adjournment, President Davis reminded The Council of action taken by The Council on April 20, 1953, when The Council decided that a suitable gift should be presented by the Association to Mr. Nelson, the Executive Secretary, in recognition of his 25-year service to the Association, he having joined the staff of the Columbus office in November, 1928. Dr. Davis then called on Dr. Brindley, who, with Dr. Meiling and Dr. Heusinkveld, had been designated to arrange for the gift and its presentation. Dr. Brindley then made the presentation which was a cash gift. Mr. Nelson responded by expressing his sincere thanks for the sentiments expressed and the generosity of The Council and stated that he would do everything possible to continue to give the medical profession of Ohio loyal, devoted and efficient services.

Attest: CHARLES S. NELSON,
Executive Secretary.



At an informal gathering during The Council meeting in Granville Charles S. Nelson (left), Executive Secretary, was presented a cash gift "in recognition of his loyalty, devotion, and outstanding performance, above and beyond the call of duty, in the interests of the Ohio State Medical Association during the past quarter century." The gift was authorized by The Council in an executive session held during the Annual Meeting in Cincinnati last April.

Mr. Nelson started with the Association as Assistant Executive Secretary on November 17, 1928, and succeeded to the position of Executive Secretary May 1, 1935.

Dr. A. A. Brindley, Toledo, Past-President of the Association and chairman of a special committee appointed to recommend suitable recognition, is shown making the presentation.

O.S.U. College of Medicine . . .

School Opens With First Maximum Enrollment of 600; Nursing School Also Shows Increase; Dr. McCormick Delivers Convocation Address

THE Ohio State University College of Medicine, at a Convocation opening its 121st consecutive academic year, was honored by the presence of the President of the American Medical Association, Dr. Edward J. McCormick, of Toledo, principal speaker for the occasion, and Dr. John H. J. Upham, Past-President of the A. M. A. and Dean Emeritus of the College. The Convocation was significant also from another angle. It marked the beginning of the first year in which the College of Medicine has achieved its maximum enrollment under the expanded program.

Dr. Howard L. Bevis, President of the University, welcomed freshman medical students and freshman nursing students in the name of the institution. The Convocation was held in the Museum Auditorium on the O. S. U. Campus on September 29, and in addition to freshman medical and nursing students included upper classmen of both schools.

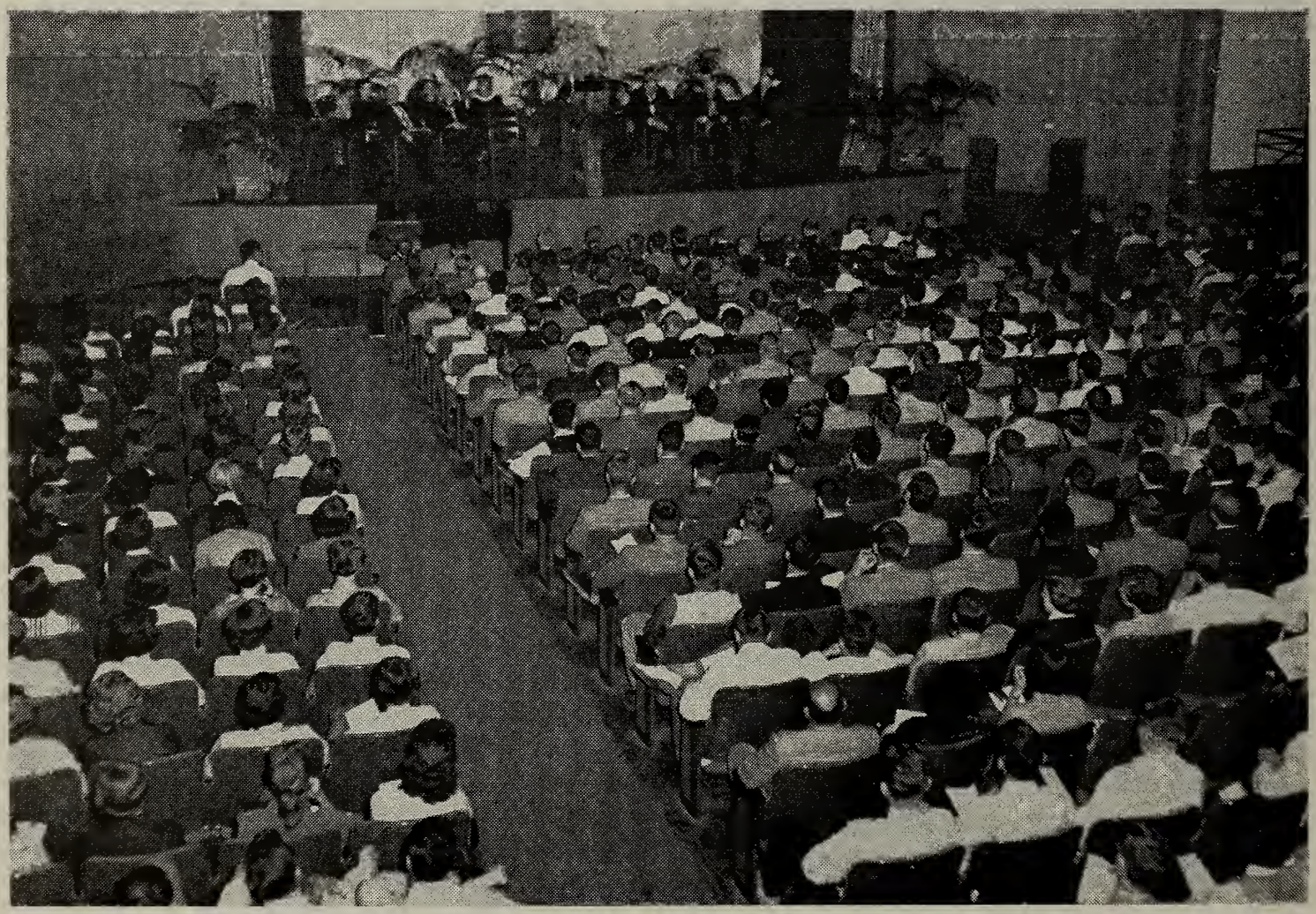
DR. McCORMICK PUTS STANDARD HIGH

Dr. McCormick threw down a three-fold challenge to the freshman medical and nursing students. It was a challenge for the coming physicians to take their places in the midst of the greatest period of medical advancement in history; it was a challenge for them to assume responsibility with 150,000 or more members of the "greatest service organization in the world"—the American Medical Association; and it was a challenge for them to "dedicate" their lives to alleviating the suffering of mankind.

Dr. McCormick reviewed the tremendous advances in medicine, in surgery and in research during the past quarter of a century and directed the thinking of his audience into the next quarter of a century where he declared "the horizons are unlimited." He predicted that within the next few years methods will be discovered to control cancer, poliomyelitis and many other diseases.

A. M. A.—A SERVICE ORGANIZATION

Turning to medical organization, Dr. McCormick declared that "the A.M.A. is the greatest service organization in the world." Through its Councils and Committees, he said, the A. M. A. is dealing realistically with the problem of more doctors for rural communities, more thorough



This Convocation in the Museum Auditorium on the O. S. U. Campus opened the 121st consecutive year of the College of Medicine. It included students from the School of Nursing.

A. M. A. Presidents, Past and Present, Are Honored



Photos by O.S.U. PR Dept.

Special honor was paid at the Convocation to Ohio's two Presidents of the American Medical Association—Dr. John H. J. Upham, Columbus, who also is Dean Emeritus of the College of Medicine, and Dr. Edward J. McCormick, Toledo, this year's President. Left to right above are Dr. Upham, Dean Charles A. Doan, Dr. McCormick and Dr. Richard L. Meiling, Associate Dean of the College, wearing the Academic Robes awarded him last year at the University of Munich.

coverage of the people by voluntary medical and surgical insurance and hospital insurance, equitable distribution of doctors in the Armed forces, health of workers in industrial plants, care for the indigent, chronic illness, and many other similar problems.

He reminded his audience that few of those present could afford a medical education if the full cost were passed on to them in the form of tuition. The American Medical Association, he said, has given more than two million dollars toward support of medical colleges within the past few years through the American Medical Education Foundation. The Student A. M. A., he further pointed out, was organized and supported initially by the A. M. A.

Largely through the efforts of the A. M. A. Council on Medical and Hospital Services the standards of medical colleges has been raised to the point where every college in the United States is now rated Class A. Medical education and medical standards in this country have risen to the point where doctors from all parts of the world now look to America for what is going on.

EMPHASIS ON SOCIO-ECONOMIC

He emphasized the necessity for medical schools to place more emphasis on social and economic problems involved in the practice of medicine.

In regard to the increased emphasis on specialization, Dr. McCormick said that he is convinced and that the policy of the A. M. A. backs up that conviction, that the general practitioner is still the backbone of the medical profession and that the A. M. A. is trying to bring back to the general practitioner the credit that rightfully belongs to him. He predicted that within the next eight or so years that there will be doctors in virtually all of the outlying communities where they are needed.

Dr. McCormick concluded his talk by challenging the prospective doctors and nurses to pursue their occupations in the "priestly" manner without thought of pay. "You don't have to worry about pay if you are a good doctor or nurse," he said. In regard to much emphasis on doctors who fail to live up to the Code of Ethics, he pointed out that doctors like clergymen or persons in other professions always make news when they fail to live up to their obligations to humanity.

DEAN DOAN SPEAKS

It was Dr. Charles A. Doan, Dean of the College of Medicine, who announced that this school year, for the first time the O. S. U. College of Medicine has accomplished its maximum enrollment goal of 600 medical students. Three years ago this fall, he pointed out, the college began taking in 150 freshman students, just double the

number accommodated in the immediate pre-war years.

It has been possible to expand the post-doctoral educational training program, also, with the increase to 1,402 in hospital care and teaching beds under the University's control, he said. The expanded program will accommodate 156 interns, residents and research fellows to serve with an expanded medical faculty of 304.

Within the School of Nursing an even greater proportionate expansion has been taking place. With an entering class of 50 three years ago. the school attracted 153 freshman girls last fall and 142 this fall. There are 340 registered nurses, supervisors and instructors currently in the three hospitals on the campus.

The College of Dentistry, "with which we have the closest ties and affiliations," is also currently expanding its student body commensurate with the new physical plant, the Dean said. The School of Optometry, located also in the Health Center, maintains close cooperation with the Department of Ophthalmology through the Institute for Research in Vision.

AUXILIARY PROGRAMS

Special technical and administrative programs, all developed as part of the educational program, include dietetics, occupational therapy, physical medicine, clinical pathology, dental hygiene, medical social service, hospital administration, medical art and many others.

Dr. Doan concluded his talk with a charge to the medical students to cherish the Hippocratic tradition "the unenforceable though spiritually binding ethical laws of the Medical Community," which he described as the oldest and still highest in their idealism of any which present day society recognizes.

Northwestern Ohio Physicians Elect Officers

The Northwestern Ohio Medical Association, comprising physicians of the Third and Fourth Councilor Districts, at its meeting in Toledo, October 14, elected the following officers: Dr. Henry L. Abbott, Tiffin, president; Dr. Boyd Travis, Bluffton, vice-president; Dr. Henry B. Larzelere, Toledo, secretary, and Dr. F. A. McCammon, Van Wert, treasurer.

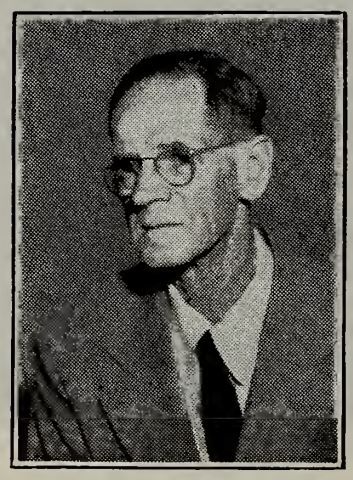
Cleveland—$100,000 has been appropriated to revamp a wing of City Hospital to take care of children with pulmonary tuberculosis and related diseases. Dr. Frederick C. Robbins, chief of pediatrics at the hospital, will be in charge of the unit.

Toledo—Dr. Lew H. Hauman was the subject of a feature story in the magazine section of the *Toledo Blade*, the occasion being completion of 50 years of practice.

Cleveland Executive Secretary To Retire After 31 Years' Service

The man who became the first full-time executive secretary of a county medical society in the Nation is retiring after 31 years on his post. He is H. Van Y. Caldwell, of the Cleveland Academy, whose retirement becomes effective December 1.

Mr. Caldwell joined the staff of the Cleveland Academy in 1922, after earlier experiences which included teaching college English, reporting for a Cleveland newspaper and engaging in other association executive work. He is a graduate of Amherst College and did postgraduate work at Columbia and Ohio State University.



VAN CALDWELL



JOHN HANNI

Mr. Caldwell will return to his native New England, where he and Mrs. Caldwell have purchased a home in Chatham, Mass., on Cape Cod.

Mr. Caldwell has pioneered in medical organization work on the local level in its effort to relate itself to the community. He has witnessed the growth of medical organization in his and other communities to the point where there are now more than 200 county medical societies in the nation which maintain full-time staffs headed by executive secretaries. Eight county societies in Ohio now have staffs headed by full-time lay executives and one has a part-time executive.

The Caldwells have two sons, one the editor of the trade publication *Steel* and the other an insurance executive.

Assuming the post of executive secretary of the Cleveland Academy on December 1 will be M. John Hanni, Jr., who joined the staff as assistant executive secretary in June of this year.

Mr. Hanni received his master's degree from Western Reserve University after graduating from Ohio Wesleyan in 1948. He came to the Academy from the Euclid Road Machinery Company where he held the post of assistant sales promotion manager and prior to that was assistant dean of men at Western Reserve. Mr. Hanni also is a veteran of World War II having served three years with the Air Force.

Are You Planning . . .

to attend the 1954 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION in COLUMBUS, APRIL 12-15? If so, it is an excellent plan to make HOTEL RESERVATIONS well in advance to assure the best accommodations. This list of leading downtown Columbus hotels is given for your convenience. It isn't too early to clip the coupon at the bottom of this page and mail it to the hotel of your choice.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NEIL HOUSE	$5.50-7.00	$8.00-10.00	$10.00-13.00
DESHLER-HILTON HOTEL	$5.00-9.00	$9.00-13.50	$ 9.50-14.50
HOTEL FORT HAYES	$5.50-8.00	$8.50-10.00	$10.00-11.00
SENECA HOTEL	$4.00-6.00	$6.00- 8.00	$ 8.00-10.00
SOUTHERN HOTEL	$5.00-6.00	$6.50- 8.50	$10.00-11.00
HOTEL VIRGINIA	$4.50-5.00	$7.50- 8.00	$ 8.00- 9.00
HOTEL CHITTENDEN	$3.50-4.00	$5.00- 6.75	$ 6.75-10.50

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.

(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 12, 13, 14, 15, 1954, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April ..... at .....A.M..... P.M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

.....

FIRST CALL FOR ENTRIES IN

Scientific and Educational Exhibit

1954 Annual Meeting, Ohio State Medical Association

April 12-15, Columbus, Ohio

OUTSTANDING among the features of the 1954 Annual Meeting of the Ohio State Medical Association, April 12, 13, 14 and 15, Columbus, Ohio, will be the Scientific and Educational Exhibit. This Scientific and Educational Exhibit will be at the Deshler-Hilton Hotel where many of the program sessions will be held. The Neil House also will be used for program sessions and will house the Technical Exhibit. The hotels are only one-half block apart.

This is a general invitation to members of the Ohio State Medical Association as well as others to participate. If you have display material which will be of scientific or general educational value, why not put it on display?

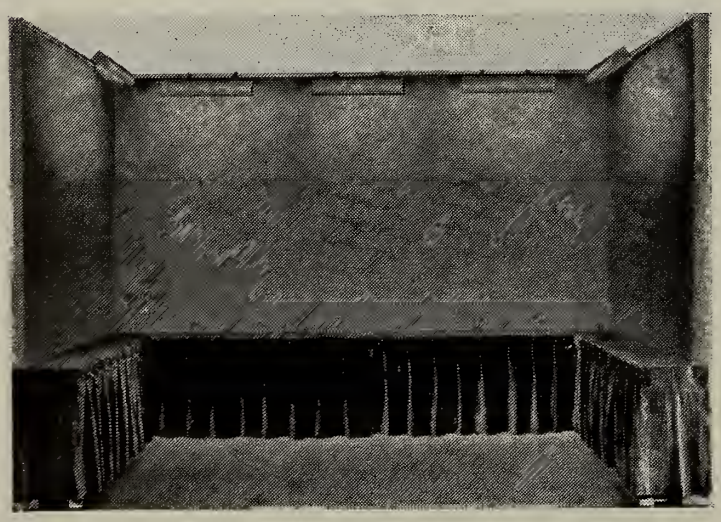
Exhibit material does not have to be strictly scientific. If it presents data which will be of general educational value to the medical profession, it will be considered by the committee which has full authority to accept or reject applications at its own discretion.

On the opposite page will be found an application blank. If you have material suitable for an exhibit send in an application. If you know of a colleague or group of physicians who have interesting material to display suggest that they do the same.

The Scientific and Educational Exhibit will be in the Foyer, Main Ballroom, Deshler-Hilton Hotel. Many program sessions will be held in the same hotel.

The firm which has been handling exhibits for the State Meeting and which handles exhibits for the American Medical Association—ADD, Inc., Cleveland—again will supply equipment and supervise erection of exhibits. These people are thoroughly experienced and do a smooth, professional job.

Equipment and facilities similar to that used at A. M. A. meetings will be used. The accompanying picture shows the type of booth which will be provided.



Type of Booth To Be Used for Scientific Exhibits

Booths will be uniform color and design, solidly constructed of wood and wallboard and skirted with velour. A shelf will surround three sides with the upper area covered with taut blue crash fabric for bulletin board background. This material will permit the tacking or taping of charts and specimens without fear of damaging the exhibits. Fluorescent lights are a part of the background.

APPLICATION

For Space in the Scientific and Educational Exhibit

1954 Annual Meeting • Ohio State Medical Association

DESHLER-HILTON HOTEL COLUMBUS, OHIO APRIL 12-15, 1954

Fill Out and Mail to:

GEORGE J. HAMWI, M. D., *Chairman*
Committee on Scientific and Educational Exhibits
Room 1138, University Hospital,
Ohio State University,
Columbus 10, Ohio

---

1. Title of Exhibit:_____
2. Description or nature of exhibit (attach 200-word description to this blank).
3. Will radiologic viewing boxes be needed? If so, state number and size:
   Number of boxes needed_____ Size required_____
   (Please indicate if you plan to furnish own view box.)
4. Will you require shelf space? If so, how much?_____
5. How much floor space will you require?_____
6. How much back wall space will you require?_____
7. How much side wall space will you require?_____
8. Other material or equipment required:_____
9. Name of exhibitor: _____
   _____ (Street) _____ (City)
10. Name of institution cooperating in exhibit (if desired) :

_____

_____

_____

Cost of transporting exhibits to the meeting must be borne by individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

1954 Annual Meeting . . .

Preliminary Arrangements Made by Committee on Scientific Work; Schedule for Session, April 12, 13, 14 and 15, Approved by Council

PRELIMINARY arrangements have been made for the 1954 Annual Meeting of the Ohio State Medical Association, April 12, 13, 14 and 15, Columbus. Sessions will be held at the Neil House and Deshler Hilton Hotel.

Registration Headquarters and the Technical Exhibit will be housed at the Neil House. The Scientific and Educational Exhibit will be at the Deshler Hilton. Scientific sessions will be held at both hotels.

One innovation of the 1954 meeting will be designation of Monday, April 12, the first day, as "Specialty Society Day." This will provide an opportunity for specialty societies to meet for business, organization and social meetings. Section sessions on Tuesday have been geared to "Specialty Society Day," so far as possible, in order that those attending meetings of their specialty society can conveniently stay over for section programs.

Initial plans for the 1954 meeting were made on September 13 when the Committee on Scientific Work met at the Columbus Office in the morning and then held a joint meeting in the afternoon with the chairmen and secretaries of the various Scientific Sections. A number of joint meetings of some of the sections are being planned and will be announced later. It is anticipated that many of the out-of-state guest speakers will address both general and section sessions.

The Annual Conference of County Medical Society Officers and Committee Chairmen will be held on Tuesday afternoon and evening, April 13. The program for that conference will be announced later.

Thursday afternoon, April 15, the final day of the meeting, has been set aside as "Allied Health Organization Day." It is anticipated that a number of organizations in that category will plan to have meetings that afternoon which will be of interest to physicians.

As in previous years, the Scientific and Educational Exhibit will constitute a major feature of the Annual Meeting. Dr. George J. Hamwi, associate professor of medicine at Ohio State University College of Medicine, has been named chairman of the Committee on Scientific and Educational Exhibits. He is now in process of naming members of his committee. On pages 1016 and 1017 of this issue are details about the exhibits and an application form which prospective exhibitors may use. A general invitation has been issued for members of the Association and others to participate.

Following is a schedule of Annual Meeting events, the details of which will appear in the Official Program which will be published in the March issue of *The Journal.*

Sunday, April 11

6:00 P. M.

Council dinner and business session.

Monday, April 12

"Specialty Society Day"

Meetings of various specialty societies.

6:00 P. M.

Dinner for House of Delegates and Business Session.

Tuesday, April 13

9:30 A. M. to 12:00 Noon

Section Meetings.

2:00 P. M. to 3:30 P. M.

General Session—Guest Speakers.

3:30 P. M. to 5:30 P. M.

Conference of Officers and Committee Chairmen of County Medical Societies.

6:00 P. M.

Buffet Supper for County Society Officers, etc.

7:30 P. M.

Conference of County Society Officers (continued).

Wednesday, April 14

9:30 A. M. to 12:00 Noon

Section Meetings.

2:00 P. M. to 4:00 P. M.

General Sessions—Guest Speakers.

7:30 P. M.

Annual Banquet.

Thursday, April 15

8:00 A. M.

House of Delegates Breakfast and Business Session.

9:30 A. M. to 12 Noon

General Session—Guest Speakers.

2:00 P. M.

Exhibits close.

2:00 P. M. to 4:00 P. M.

Meetings of Allied Health Organizations.

Cited for NEPH Work . . .

State Recognition Puts Dr. Perry in Line for National Award; Citation Is Based on Rehabilitation of Physically Handicapped

DR. CLAUDE S. PERRY, Columbus, has the distinction of being the first Ohio physician to be nominated on a state-wide basis for the President's Physician Award authorized in connection with the National Employ the Physically Handicapped program, and on the basis of his nomination has been issued a special citation from Ross T. McIntire, Washington, D. C., chairman of the President's Committee on N. E. P. H.

Governor Frank J. Lausche presented the citation to Dr. Perry at special ceremonies in the Governor's office on September 25, and added his personal commendations and congratulations to Dr. Perry for his outstanding contributions to rehabilitation of the handicapped workers.

The President's Physician Award will be presented some time next year to a physician selected from the various state nominees. In previous years the award has been given to such men as Dr. Howard A. Rusk, of New York, and Dr. Harry Kessler, Washington, D. C., both actively engaged in rehabilitation work for the Veterans Administration and other national agencies.

This is the first time an Ohio physician has been nominated for the award, the nomination being made by the Ohio Inter-Agency Employ the Physically Handicapped Committee.

The citation was in recognition of Dr. Perry's "outstanding efforts extended in promoting equal opportunity in employment of the physically handicapped." Dr. Perry's work with handicapped persons, in keeping with his specialty, is in the field of sight saving and rehabilitation of the blind.

The Ohio committee's nomination report on Dr. Perry to the national committee points to the

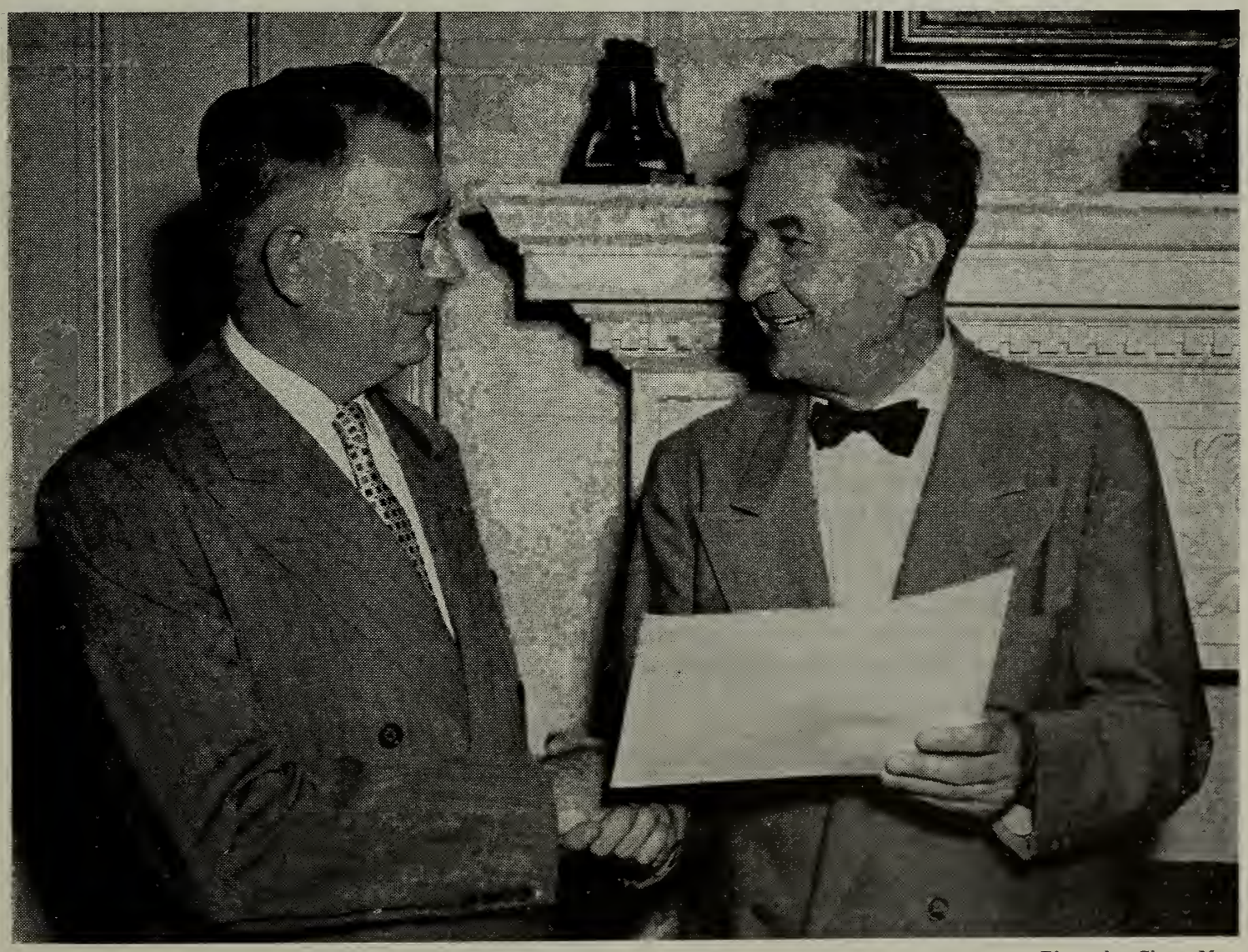


Photo by Chas. Moor

Dr. Claude S. Perry (left) is receiving the commendation of Governor Frank J. Lausche as he receives the national citation at the Governor's hand. The special ceremonies were held in the Governor's office.

following fields of endeavor: His accomplishments and contributions in the development of surgical techniques; his work with numerous agencies and organizations interested in the visually handicapped; his efforts to promote legislation in the interest of sight saving; his record with the Armed Forces, and his private practice which extends to many who can pay little or nothing for his services.

ACHIEVEMENTS ENUMERATED

Following are excerpts from Dr. Perry's record as related in the Ohio Committee's nomination:

"In the field of legislation he played a leading role in securing enactment of the Ohio law providing immediate emergency hospital and medical care for those infants having gonorrheal conjunctivitis. . . . Another legislative landmark activity supported by Dr. Perry was the enactment of the Ohio Fireworks law which prohibits sale to or possession of fireworks by the general public.

"Dr. Perry is the State ophthalmological consultant for the Division of Social Administration, in its program of public assistance to the blind, and Vocational Rehabilitation Services for the blind; chief ophthalmologist for the Ohio State School for the Blind; and associate professor of ophthalmology Ohio State University College of Medicine. . . .

"His work at the State School for the Blind has gone beyond that of a physician for he has counseled with and advised the students in regard to job choices and vocational training compatible with their eye conditions.

"During World War II, Dr. Perry served as a Lt. Colonel with the U. S. Army, 76th General Hospital. He is the recipient of two decorations and the Purple Heart. The Bronze Star was awarded him for his inventive genius in developing a prosthetic eye implant during the Battle of the Bulge. This technique when used on the battle field or the emergency front line medical station was instrumental in preserving the appearance of the soldier.

"Dr. Perry developed the technique and performed the first such operation for intra-capsular cataract extraction in small animals. This work was done in cooperation with the Ohio State University Veterinary College. . . .

"Literally hundreds of individuals today owe in part their success in occupational adjustment to Dr. Perry's medical, legislative or counseling activities."

DR. BEARZY RECOGNIZED

A similar citation, given on a regional basis, was presented to Dr. Herman J. Bearzy, director of the Department of Physical Medicine and Rehabilitation of the Miami Valley Hospital, Dayton. Dr. Bearzy's citation was based on recommendation of the Dayton Community Employ the Physically Handicapped Committee.

Governor Lausche, at the same time that he presented the citation to Dr. Perry, signed a proclamation setting aside the week of October 4-10 as National Employ the Physically Handicapped Week in Ohio. The designated week culminates year-round education program designed to encourage employers to fit physically handicapped persons into their working forces.

What To Write for

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room.

* * *

"The Pre-School Child Who Is Blind," . . . 22-page illustrated guide for parents . . . 10 cents, from Supt. of Documents, Washington 25, D. C.

Proceedings of National Food and Nutrition Institute, held last December . . . 65 cents from Supt. of Documents.

The American Medical Association, Its History, Activities, and Progress" . . . limited copies free from Public Relations Dept., A. M. A., 535 North Dearborn St., Chicago 10.

"School Health Problems," by Laurence B. Chenoweth, M. D., director of Dept. of Hygiene and Student Health Service, University of Cincinnati, and Theodore K. Selkirk, M. D., assistant professor of pediatrics, U. of C. College of Medicine, 4th edition, four dollars, from Appleton-Century-Crofts, Inc., 35 W. 32nd St., New York 1.

"Survey of Prolonged Non-Occupational Illness Among Employed Persons," Nature, Extent and Economic Aspects, Publication No. 90; and "Prolonged Non-Occupational Illness," 1st Progress Report, Publication No. 95 . . . Research Council for Economic Security, 111 W. Jackson Blvd., Chicago 4.

"A Doctor for Your Community" . . . suggestions for use of communities in obtaining physicians . . . free from Council on Medical Service, A. M. A.

"Quarterly Cumulative Index Medicus," volume 50, covering the literature for last half of 1951 . . . available for purchase from A. M. A.

A listing of all Public Health Service publications issued during 1952 . . . available upon request to Public Inquiries Branch, U. S. P. H. S., Department of Health, Education and Welfare, Washington 25, D. C.

"Points to Remember When You Buy a Home," free from the Ohio State Bar Association, State House Annex, Columbus 15, Ohio.

Ohio Medical Indemnity . . .

New Home Office Building To Be Built by Company, Sponsored by O.S.M.A.; Site on North High Street, in Suburban Columbus Picked

CONSTRUCTION will be started in the near future on a new home office building for Ohio Medical Indemnity, Inc. It will be erected on North High Street, Columbus, between Arden and Fallis Roads, an extremely desirable area of suburban North Columbus.

Plans for the building, which will be a two-level, brick-faced structure with all the features of an up-to-date office building, have been under study for more than a year by the Board of Directors of Ohio Medical.

At a recent meeting of the Board of Directors, the board authorized the employment of architects and construction of the building, after reviewing carefully recommendations received from a special building committee and the Executive Committee of O. M. I.

EXPANSION IS GREAT

From the first year of its existence, when Ohio Medical reached an enrollment of 75,000 and an average of 114 claims processed each month, the company has steadily increased in size to its present all-time high of 1,500,000 subscribers. The average number of claims handled each month is 15,000. Nearly $750,000 is now being returned to members in the form of indemnity payments each month.

As Ohio Medical grew in enrollment, it found it necessary to expand its facilities. At its conception in 1945, Ohio Medical was a one-employee organization, occupying one room in the Hartman Theatre Building. It now has 40 employes. The present location, utilizing 4500 square feet of space on two floors of the Beggs Building in downtown Columbus, was the result of expansion through three previous office sites.

EFFICIENTLY-ORGANIZED SPACE NEEDED

In mid-1952, the Board of Directors recognized that, from the pattern of growth evidenced in the past, the present facilities, though adequate for current needs, will soon be inadequate. Additional and more efficiently organized space than is possible in the present site will be needed—in fact is needed now—to carry out the every-day business of processing, checking, reviewing and corresponding that is necessary to the final disposition of any one of the many claims that is daily routed through the Ohio Medical offices.

In July, 1952, the Board appointed a special committee to study the problem. This committee found that a downtown location was not essential for Ohio Medical, since the vast majority of its transactions are handled by mail. Minimum requirements for the new location were determined to be ease of access to normal city transit routes, location in a desirable section of the city, and efficiency of structural design.

ALL POSSIBILITIES EXPLORED

For over a year the committee considered many possibilities which, after thorough investigation, were rejected. Rental of additional space in the present location was not possible. Other downtown buildings offered no solution to the need for expanded facilities. Also, rental which would have to be paid for adequate downtown space was found to be extremely high.

Rental of buildings not in the downtown area was considered. However, these buildings were found to be unsuitable to Ohio Medical's needs.

The committee next concentrated its attention on the advisability of buying a building. Investigation showed that in almost every instance extensive alterations would be necessary to meet the requirements of Ohio Medical or the buildings were not in desirable locations.

FINAL ACTION BY BOARD

The problem resolved itself through the process of elimination to final consideration of purchasing a lot and building a structure of suitable design. The lot at 3766 North High was selected by the committee and approved by the board.

The building will be so constructed that future expansion can be handled with a minimum of cost in alteration. A parking area will be provided to the rear of the building to allow ample facilities for employees and visitors. No definite estimate can be made now on the cost of the new building as drawings and specifications have not been completed. However, the Board of Directors anticipates a suitable structure can be completed at a cost of between $125,000 and $150,000.

* * *

Ohio Medical Indemnity Adds "Preferred" And Non-Group Contracts

In the fall of 1951, The Council of the Ohio State Medical Association recommended to the Board of Directors of Ohio Medical Indemnity, that "Ohio Medical initiate steps for the drafting of a new indemnity contract providing for increased indemnities . . . and that consideration be given to including additional services and benefits . . ."

In the fall of 1952, Ohio Medical had completed this contract. It provides higher indemnity payments for surgical services and the

maximum benefit is raised from $200.00 to $300.00. In addition, anesthesia, when administered by a physician, is considered a benefit and is paid on a specified schedule.

ENROLLMENT REGULATIONS

The same enrollment regulations apply to the "Preferred" Contract as to the Standard Contract. However, a group now enrolled in the Standard Contract, and wishing to convert to the "Preferred" Contract must transfer all standard contract holders. This was deemed essential for the actuarial soundness of the plan and to overcome the objections of many employers to varied payroll deductions.

The monthly charges for the "Preferred" Contract are: $1.00 for single, and $3.00 for family. The Standard Contract charge is $.60 for single, and $1.90 for family.

The "Preferred" Contract has been offered to many groups throughout the state. As of August 31, 1953, 16,069 persons were enrolled in the "Preferred" Contract. Total enrollment under all contracts as of October 1, was 1,557,443.

NON-GROUP CONTRACT

Another important development by Ohio Medical in the past year was the introduction of the Non-Group Contract. That contract cannot be as attractive as that sold on a group basis. This contract has been offered only in the Columbus area until the mechanics of handling were developed. Because of the liberality of coverage in the popular "Standard Contract" extreme care has been taken to explain the limitations of the Non-Group Contract. A new approach has been attempted in this contract—instead of excluding or placing waiting periods on "pre-existing conditions," certain operations that have a twelve month waiting period have been specified and diseases excluded from the hospitalized Medical Care portion of the contract have been named. These are shown in a receipt given to the subscriber at the time of enrollment.

To date Ohio Medical has approximately 5,000 subscribers covered in this Non-Group Contract and in the coming year, plans are being made to expand it to other areas of the state.

Columbus—Dr. Hugh J. Means has retired as professor and chairman of the Department of Radiology, Ohio State University College of Medicine. Dr. Means has been on the faculty of the College since its inception in 1914 and six years prior served on the faculty of the Starling-Ohio Medical College.

Newark—Dr. Joseph W. Barker was honored at a dinner of the Y. M. C. A. board of directors at which he was presented the Y.'s National Council award and a citation from the Newark Community Chest. Dr. Barker has served many years as a director and president of the board.

Cleveland Area Heart Society To Give Fourth Annual Program

The subject of congenital heart disease will be stressed at the scientific sessions of the fourth annual meeting of the Cleveland Area Heart Society in the Hotel Hollenden, Cleveland, on Wednesday, November 18.

The meeting will be divided into morning and afternoon sessions for practitioners, culminated by an open forum for the public in the evening at the Public Auditorium. The evening session will be one of the series of public forums being sponsored in Cleveland.

MORNING SESSION

Chairman, Dr. A. Carlton Ernstene

9:00 - 9:20 a. m.—Two Decades of Advances in Studies of Congenital Heart Disease, Dr. Harold Feil.

9:20 - 9:40—Considerations of the Pathology of Congenital Heart Disease, Dr. Harrison Latta.

9:40 - 10:10—Embryology of Congenital Defects of the Heart, Bradley M. Patten, Ph. D.

10:10 - 10:30—Pathologic Physiology of Congenital Heart Disease, Dr. F. Mason Sones, Jr.

10:30 - 10:40—Intermission.

10:40 - 11:00—Clinical Manifestations of Congenital Heart Disease, Dr. W. H. Pritchard.

11:00 - 12:00—Laboratory Studies and Tests in Congenital Heart Disease: (A) The Electrocardiogram, Dr. H. K. Hellerstein; (B) X-Ray and Angiocardiography, Dr. D. R. Keating; (C) Cardiac Catheterization, Dr. B. L. Brofman.

12:00 - 12:30—Open Forum.

Luncheon, Hollenden Hotel.

AFTERNOON SESSION

Chairman, Dr. Claude S. Beck

2:00 - 2:20—Medical Management of Patients with Congenital Heart, Dr. Samuel Spector.

2:20 - 2:40—Surgical Treatment of Congenital Aortic Anomoly, Dr. D. B. Effler.

2:40 - 3:00—Surgery of Septal Defects, E. B. Kay.

3:00 - 3:20—The Future of the Extracorporeal Pump in the Surgical Treatment of Congenital Heart Disease, Dr. G. H. A. Clowes, Jr.

3:20 - 3:30—Open Forum.

3:30 - 4:30—Clinicopathological Conference, Dr. R. W. Scott and Dr. Rafael Dominguez.

EVENING MEETING—PUBLIC FORUM

Cleveland Area Heart Society in collaboration with the Academy of Medicine and the *Cleveland Press*. Panel: Dr. Claude S. Beck, Lakeside; Dr. A. C. Ernstene, Cleveland Clinic; Dr. Roy W. Scott, City Hospital; Dr. J. T. Ledman, Lakewood Hospital; Dr. Harold Feil, Lakeside.



Various factors during pregnancy (intestinal displacement, atony, inactivity) make it virtually impossible for most women to go through the gestation period without constipation.

CONSTIPATION IN PREGNANCY:

Satisfactorily controlled with Metamucil®

Metamucil, with its physiologic principles of "smoothage" and "normohydration," is well tolerated for pregnancy constipation. This bland vegetable colloid may be used throughout the entire nine-month period without fear of forming a "habit" and without irritation to the mucosa.

Greenhill[1] suggests that Metamucil be given every other night. He also recommends that Metamucil be given in conjunction with a proper diet, during the lying-in period of the puerperium.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Greenhill, J. P.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951, pp. 103-104; 311; 332.

SEARLE Research in the Service of Medicine

Here Are the Facts . . .

Article by Dr. McCormick Clarifies the Confusion Which Originated From Erroneous News Story About Policy on Physician-Hospital Relations

IN the October issue, reference was made (page 914) to the confusion created by a news story on the American Hospital Association meeting in San Francisco. The news story intimated that the hospital association had taken action on the question of physician-hospital relations which was opposed to the policy of the American Medical Association. That was not true. Actually, what the hospital association did was to adopt a Hospital-Physician Relationship Statement, drafted jointly by representatives of the hospital association and the A. M. A. and which was approved last June by the A. M. A. House of Delegates. The text of the statement was published in the August issue of *The Ohio State Medical Journal*, page 730.

Nevertheless, there still seems to be some confusion as to just what did take place and about the principles agreed to. For that reason, *The Journal* is republishing herewith an article which appeared in the September 26, 1953, issue of *The Journal of the A. M. A.*, over the signature of Dr. Edward J. McCormick, President of the A. M. A. The article, which fully explains the situation, is as follows:

* * *

One of the most significant developments in the history of hospital-physician relationships was achieved at the recent annual session of the American Hospital Association in San Francisco. The House of Delegates of the A. H. A. unanimously adopted the report of the Joint Committee on Hospital-Physician Relationships, which had already been unanimously approved by the House of Delegates of the American Medical Association last June.

This action was the culmination of many months of joint meetings by trustees of the A. H. A. and the A. M. A. I personally took part in most of those sessions and know the careful thinking and the hard work that went into the drafting of the agreement. As Dr. Edwin L. Crosby, immediate past-president of the A. H. A. so ably stated: "This is a milestone in the development of better understanding between physicians and hospital administrators. It is an indication that every possible effort is being made by doctors and hospitals to provide the highest quality care to patients."

As far as I know, this was the first time that a joint committee of A. M. A. and A. H. A. trustees had ever been formed to iron out the mutual problems of doctors and hospitals and to develop working procedures that would accrue entirely to the benefit of the patient. Here are the guiding principles that were embodied in the joint report:

"1. The general purpose of hospitals and physicians is to aid each other in the delivery of the best possible medical care to patients. To attain such a purpose requires full cooperation among medical staffs, governing boards and administrative heads of hospitals. One important method of attaining this objective is that duly designated representatives of the medical staff shall have free and direct access to the governing board with due consideration to the position of the administrator as chief executive officer of the hospital. The various methods by which the medical staff may have access to the hospital governing board follow.

"a. The executive committee of the medical staff and a committee of the governing board with the hospital administrator can serve as a joint committee.

"b. Representatives of the medical staff can serve as members of the medical staff committee of the governing board with the hospital administrator.

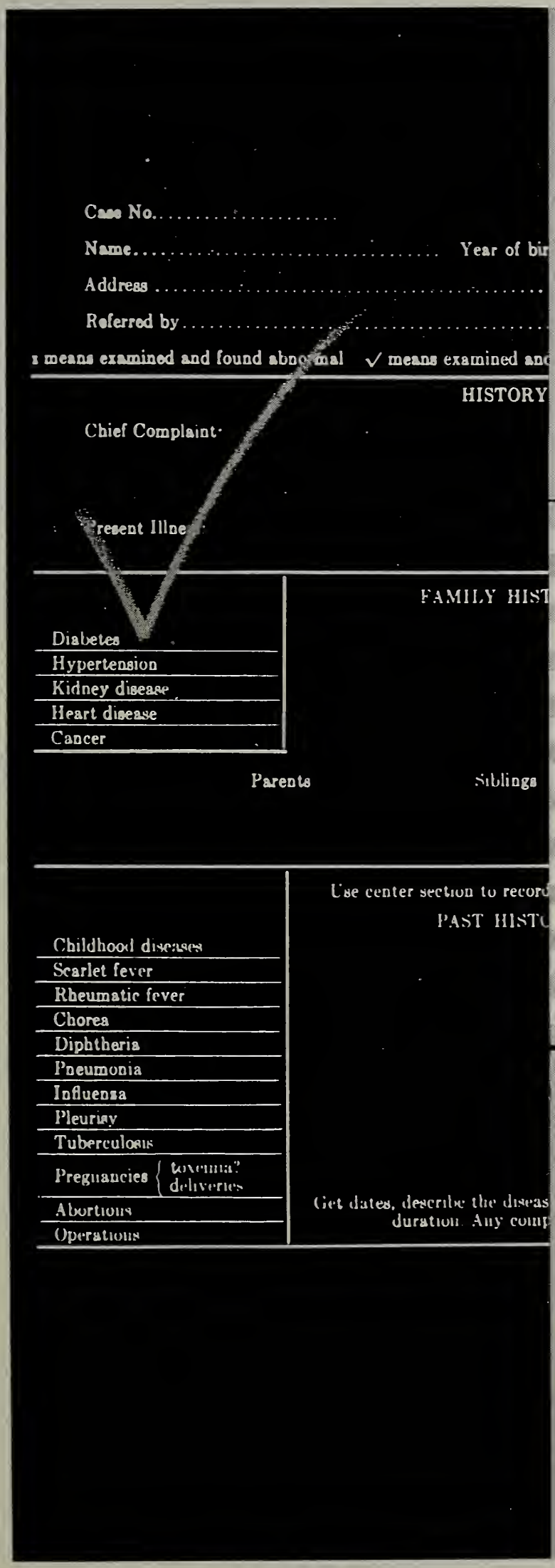
"c. Representatives elected by the medical staff can attend meetings of the hospital governing board.

"d. Members of the medical staff can be members of the hospital governing board.

"2. The professional evaluation of chiefs of service and members of the medical staff should be the responsibility of the medical profession. The method of selection of these individuals must be subject to local arrangements and local conditions. In any such arrangement, however, the principle of the freedom of the staff to make recommendations, subject to the approval of the hospital governing board, should be recognized.

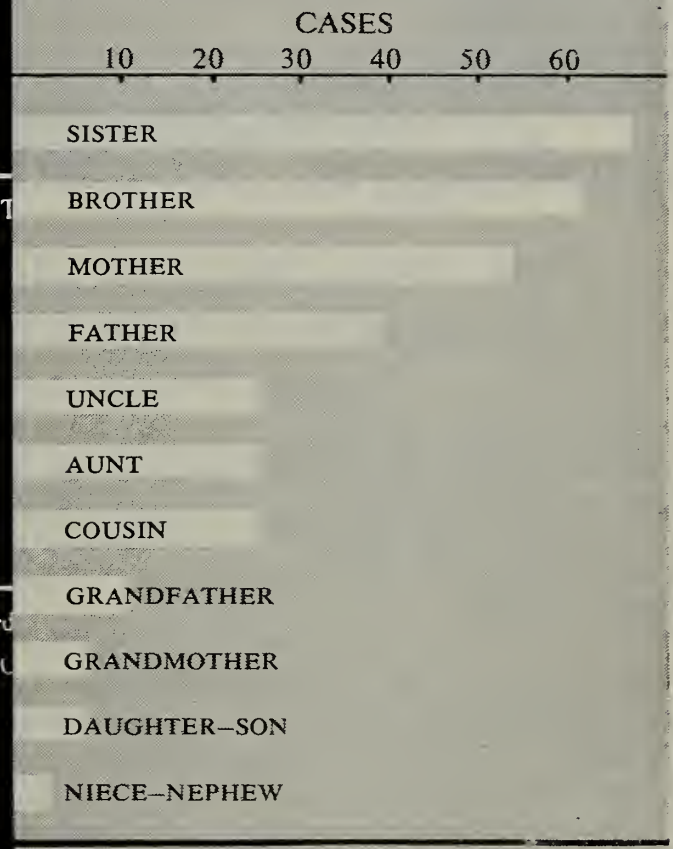
"3. The medical profession and the hospitals recognize that certain special services, such as anesthesiology, pathology, radiology, and physical medicine, are integral parts of the practice of medicine and of the services necessary for hospital patients. Physicians in these fields should have the professional status of other members of the medical staff. Chiefs in these specialties must assume also the administrative responsibilities and relationships customarily associated with such positions.

"4. The right of an individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure (a) the policy of professional incentive for the



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The Diabetic Relatives of 265 Diabetics[1]

In view of "...the very high incidence of...unsuspected cases among the blood relatives of diabetic patients,"[2] urine-sugar testing of all such individuals should be routine and frequent.

1. Barach, J. H.: Diabetes and Its Treatment, New York, Oxford University Press, 1949, p. 38.
2. Allen, F. M.: Diabetes Mellitus, in Piersol, G. M., and Bortz, E. L.: Cyclopedia of Medicine, Surgery, Specialties, Philadelphia, F. A. Davis Company, 1951, vol. 4, p. 505.

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46453

physician, and (b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered. Moreover, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organization, group, or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the patient, the hospital, or the physician.

"5. The chief of a hospital department may have access to financial information regarding his department.

"6. It is desirable that means should be provided at local, state and national levels for review of problems of individual hospital-physician relationship by organized medical and hospital groups."

The joint report consisted of 11 typewritten pages, from which the guiding principles enumerated above are excerpted. Although the statement was plainly worded and constructed so as to minimize the chance of misinterpretation, an erroneous story by the United Press did result and served to becloud an otherwise successful and enthusiastic meeting.

Nowhere in the entire report was there anything to advocate the lumping of all hospital expenses so patients would only have to pay one bill, as was incorrectly stated in the wire service story. This misleading news item set off a chain reaction that was heard across the country, but the UP failed to run a correction even when provided with a joint clarifying statement by Dr. Crosby and myself.

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

"The American Medical Association is better organized in the field of civil defense than the Federal Civil Defense Administration itself," said F. C. D. Administrator Val Peterson at a recent meeting of the District of Columbia Medical Society.

* * *

In an order issued early in October, the Veterans Administration ended the so-called "lifetime treatment" of the "service-connected tooth." This directive, effective at once, ends repeat care of non-compensable cases. It is not applicable to service-connected compensable conditions or adjunct dental care or in-patient hospital cases.

* * *

Meeting in Cleveland, September 28, the House of Delegates of the American Dental Association, for the third time since 1949, expressed opposition to old age and survivors insurance coverage of dentists under social security laws.

* * *

With the second Hoover Commission about to start work, the Citizens' Committee for the Hoover report is being reactivated. One of its announced intentions is to work for unification of all Federal medical services, military as well as civilian, according to reports.

* * *

The Food and Drug Administration is investigating the use of boric acid in infants' preparations, but has come to no conclusions, according to Associate Commissioner John L. Harvey. Mr. Harvey said that F. D. A. is reappraising the subject of boric acid toxicity and when all the facts are in, hopes to be in a position to determine whether there is a necessity for label changes or other steps to "adequately protect the public interest."

* * *

Public Health Service figures show that more than 800 communities with combined population of 15.5 million, are now fluoridating their water supplies.

* * *

A survey by the National Science Foundation shows that more than three-fourths of all federal money for scientific research and development is spent by the Department of Defense. Total estimated spending by all agencies and departments, $2,187,000 for current fiscal year.

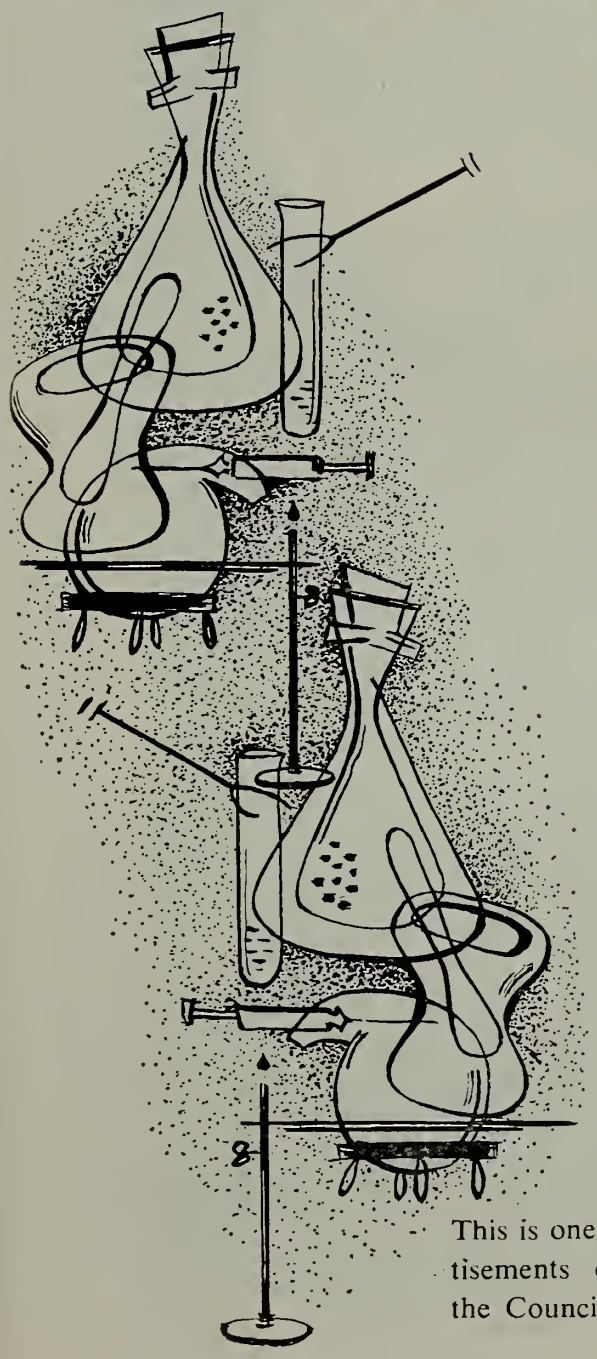
* * *

U. S. Public Health Service points out that although the military services are not accepting physician volunteers, the public health service still has openings . . . in Italy, Holland and Turkey, as well as in this country.

* * *

New director of the National Institute of Arthritis and Metabolic Disease is Dr. Floyd S. Daft, former acting director.

What is the status of____?



Many times you have asked yourself, "Is the indicated drug Penicillin . . . Chloramphenicol . . . Aureomycin . . . Sulfadiazine . . . a combination . . . or what?"
This same problem may confront you many times . . . not only with the antibiotics—but actually in any specific field where there are numerous drugs . . . and you are faced with the problem of determining which might be the therapy of choice for a given condition.

The need for such clarification has always been apparent to the Council on Pharmacy and Chemistry of the American Medical Association. Its frequent publication of special status reports in THE JOURNAL is designed to help answer such questions for you.

Information about new drugs—clinically proved indications . . . experimental uses . . . correct dosages . . . contra-indications . . . and similar facts—is frequently presented by the Council. Its announcements of newly accepted products also help keep you up-to-date on new and useful drugs. These notices which appear in THE JOURNAL almost every week can be a definite guide to you in knowing what preparations are Council accepted . . . how they are best used . . . and how they can be most effective in your daily practice.

Insistence on Council accepted products is one reliable guide to clinically tested products.

This is one of a series of advertisements designed to explain the Councils' functions to you.

ACCEPTED — COUNCIL ON PHARMACY AND CHEMISTRY — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COUNCIL ON FOODS AND NUTRITION — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COMMITTEE ON COSMETICS — AMERICAN MEDICAL ASSOCIATION

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WANTED: AN EIGHTH A. M. A. DELEGATE

Ohio can have—should have—eight delegates to the American Medical Association. Now, it has seven—one for each 1,000 physicians, or fraction thereof, who are members of the A. M. A. If just 171 additional Ohio doctors will join the A. M. A. this year—before December 1—Ohio will get another delegate in 1954. It's important that Ohio have full representation in the House of Delegates of the A. M. A. See your County Society secretary now about getting onto the 1953 A. M. A. membership rolls, if you are not a member now. Your dues might put Ohio's A. M. A. membership over the 7,000 mark and give Ohio another representative in the A. M. A. House of Delegates.

HE HAS CONFIDENCE IN OHIO MEDICAL INDEMNITY

Talk to Charles Coghlan, executive vice-president of Ohio Medical Indemnity, and he'll tell you that he gets all kinds of letters from subscribers and physicians. Most of them are the kind anyone likes to get—appreciative notes. Occasionally, along comes one which is a bit nasty. Maybe the writer is correct—maybe not.

Here's one which Ohio Medical received recently from a physician, typical of kind which gives the recipient a lift (with the names eliminated for obvious reasons):

Nelson E. Warner, Examiner
Ohio Medical Indemnity, Inc.
Columbus 15, Ohio

Dear Mr. Warner:

I am in receipt of your correspondence in regard to Mrs. ..... and to myself.

I want to take this opportunity to thank you very much for the consideration that you gave this particular case. Rest assured that it meant more than you know to this particular family.

I also agree with you that the error was mine and in the future I will make every effort to be more specific in the description of the surgery accomplished on any given patient.

I am well aware that the Blue Shield is constantly under fire in regard to the indemnity paid in one particular case, and too little indemnity paid in another case. My personal experience has been one of great satisfaction and rest assured that this particular case has only increased my faith and confidence in Ohio Medical Indemnity, Inc.

If I can help you at any time, please do not hesitate to correspond.

Sincerely yours,

....., M. D.

THE JOURNAL GETS A SHOT IN THE ARM

Have you noticed that the October issue, and this issue, of *The Journal* were brighter and snappier in appearance; easier to read? Hope so. We're using a whiter, better grade of paper stock. It's a real improvement, in our opinion.

Also, have you been following the "Public Relations" column? We're running it for your benefit—to give you hunches which may enable you to carry on better patient-physician relations in your office.

In this issue, we are publishing for the first time, "What To Write For," containing suggestions of literature which you may find of interest either for yourself or your patients. We hope to make this a regular monthly feature.

Incidentally, anytime you have ideas or criticisms regarding *The Journal*, send them along. We're always in the market for ways to improve *The Journal* and make it more useful to members.

WHY PASS UP GOOD BETS?

After the county fair in Mahoning County had closed, the Mahoning County Medical Society was presented with a special award by the fair board for bringing to the public an educational exhibit "of value to all who saw it."

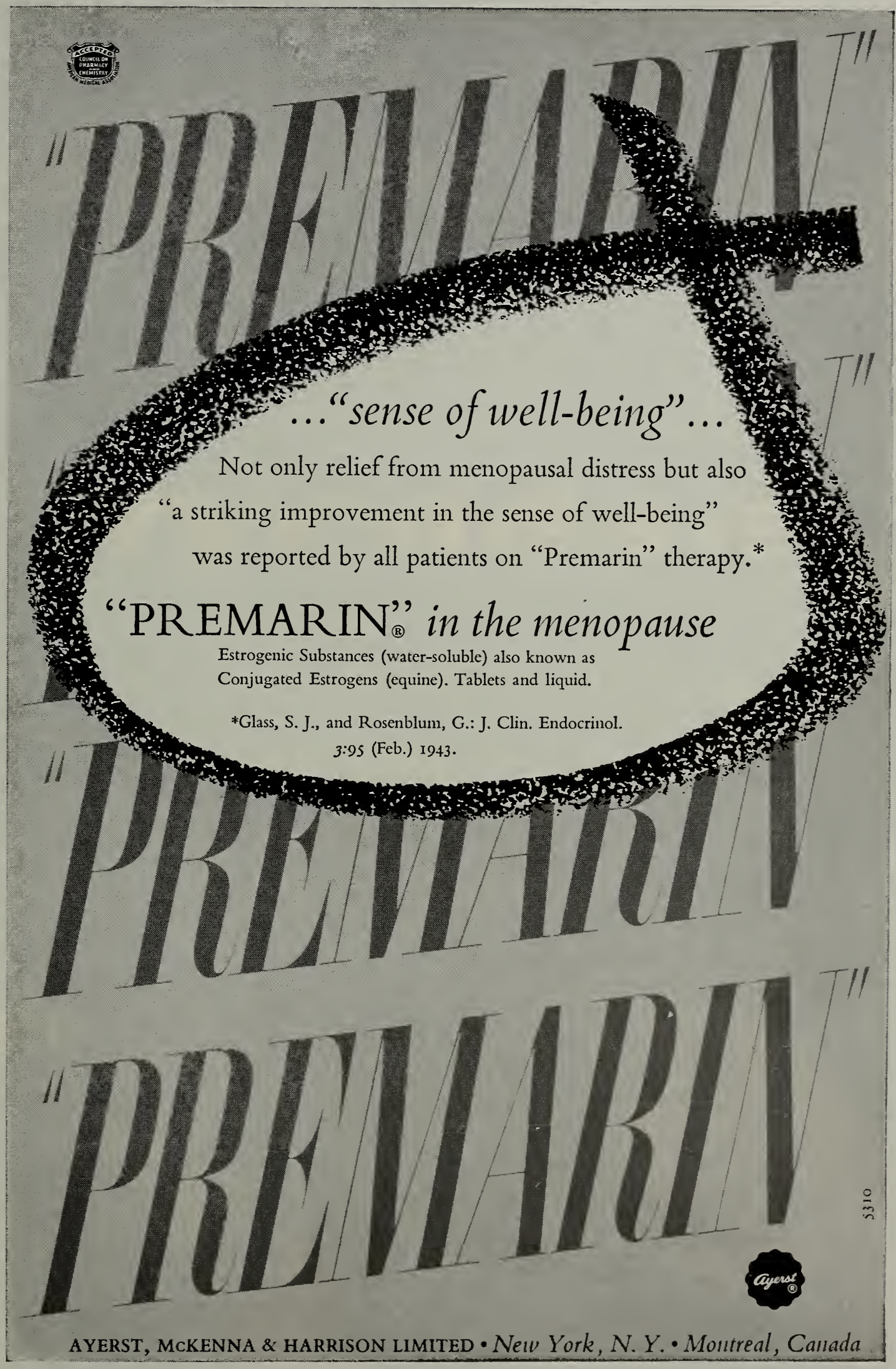
Yes, it took plenty of time and effort to plan and stage the fair exhibit. But, the effort paid tons of dividends in good public relations and sound health education for the people of Mahoning County. Medical societies all over Ohio have opportunities to do a similar job. Why pass up good bets?

FOUR H CLUBS DESERVE COOPERATION OF PHYSICIANS

One of the major objectives of the Four H Clubs of Ohio is to provide sound health education for rural boys and girls. They do a splendid job during the year which is climaxed with the "healthiest boy and healthiest girl" contest during the State Fair.

These youngsters deserve the wholehearted support and cooperation of county medical societies and individual physicians. County societies should see to it that the clubs receive advisory help from physicians. Also, the county societies could not engage in any better public relations than to arrange for members to do the physical examinations on boys and girls who enter the state contest.

Whenever the medical profession exerts a


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*Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol.
3:95 (Feb.) 1943.
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little extra effort to cooperate and work with youngsters, it is casting bread upon the waters in a manner which will yield returns many fold in the future—as the kids of today will be the patients—and the public—of the future.

Is your county society on the ball in this field?

SHALL WE LEAD OR SHALL WE BE LED?

One of the best-attended school health conferences held in Ohio in many moons was the one held some weeks ago in Tuscarawas County. That in itself is something worth talking about.

However, of equal interest and importance was the appeal sent to physicians, asking them to support the conference, by Dr. Benjamin Pilloff, president of the medical society. In part, Dr. Pilloff's pointed message said:

"I am fully aware that such a program may not appeal to those who are limiting their practice to a specialty, but the main issue resolves itself to: Shall we lead or shall we be led? There can be but one answer. We must always be the leaders in medical problems. We cannot permit this leadership to be taken away as a result of willful negligence, and taken away it will be if we fail in our inherent obligation. The sad part is, if taken away, we, the medical profession, will still have to carry out the program. For eventually, the health problems of the children are our problems, whether it is part of a school program or not. Could public relations be better served than by such meetings?"

To sum it up: Dr. Pilloff said a mouthful. Physicians who fail to realize the importance of working with the schools on health and medical problems are playing the role of the proverbial ostrich.

HOSPITAL ACCREDITATION PLAN TO BE STUDIED

Reports from various parts of the state indicate that the new hospital accreditation program has some rough spots which need to be ironed out—and promptly. The attempt to make the rigid general specifications apply to hospitals of all sizes and serving communities of different kinds is causing plenty of grumbling on the part of hospitals which are finding it impossible to meet some of the requirements.

The Council of the Ohio State Medical Association has authorized a study of the situation. A special committee of The Council, consisting of Dr. Woodhouse, chairman, Dr. Orr and Dr. Martin, has been named to collect information and evaluate the problem. If and when, the committee asks hospitals for information it is hoped that they will cooperate. Suggestions for changes in the accreditation policies and procedures cannot be submitted until the facts have been assembled.

SUPPORT FOR BRICKER AMENDMENT URGED

Support of the Bricker constitutional amendment, which stipulates that no treaty that violates the Constitution of the United States shall be valid, was urged editorially in the October 10 *Journal of the American Medical Association.*

The resolution, introduced in the 83rd Congress by Senator John W. Bricker of Ohio and 63 co-sponsors, recommends that a constitutional amendment be adopted protecting the states and the people from abuse of treaty making authority.

"The amendment establishes by unequivocal language that the treaty power cannot be used for purposes in conflict with the Constitution," the editorial stated. "It also provides that a treaty shall become effective as internal law in the United States only through the enactment of domestic legislation that could have been adopted in the absence of a treaty."

The amendment will not affect the present method of negotiating and ratifying treaties, the editorial emphasized.

The editorial pointed out that Senator William F. Knowland has submitted, at the request of the administration, a substitute resolution which differs from the Bricker amendment in that a treaty shall become effective as internal law only through the enactment of appropriate legislation by the Congress "when the Senate so provides in its consent to ratification."

This, according to the editorial, "is an old and discarded approach to the problem and one that involves no protection for American rights beyond what the people now have—which protection depends on the Senate."

"The Knowland proposal is in sharp contrast with the purpose of the Bricker amendment which would safeguard the American people against living under laws imposed by international authority, particularly when such laws take precedence over and even conflict with our own American laws, including the Constitution of the United States," the editorial concluded.

A PROPOSED REFORM WHICH IS LONG OVER-DUE

Motor vehicle owners of Ohio paid $99 million to the Federal Government during the fiscal year 1952 in the form of gasoline and excise taxes on autos and parts thereof but got back only $21 million plus in the form of highway construction funds.

During the same period, Ohio taxpayers generally paid to Uncle Sam $148,965,235 in taxes which are supposed to be used for Federal-aid programs of various kinds but got back only $98,569,227 in the form of hand-outs.

The lesson is quite obvious.

Raymond Moley stated the point clearly when



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he said that Eisenhower's desire to straighten out the mess which has developed in Federal subsidies, invasion of state activities, seizure of the taxation sources of the states, etc., "may well prove to be the beginning of his greatest single domestic reform."

The present administration certainly deserves the support of all thinking citizens in this effort to put the states back into business, handling affairs which properly belong to the states and which should be financed from local and state taxes.

Fort Steuben Academy of Medicine Announces Programs

The Fort Steuben Academy of Medicine has announced its annual series of monthly programs, with the Fort Steuben Hotel, Steubenville, as the meeting place.

The program subject for October 13 was "Indications and Contraindications for Radical Mastectomy," with Dr. Frank E. Adair, New York City, as speaker.

Subjects and speakers for coming meetings are as follows:

November 10—"Roentgen Diagnosis of Lesions of the Lung," Dr. Eugene P. Pendergrass, Philadelphia.

December 8—"Diagnostic Significance of a Lump in the Neck," Dr. Hayes Martin, New York City.

January 12—"Behavior Disorders of Children," Dr. A. A. Weech, Cincinnati.

February 9—"Surgical Aspects of Heart Disease," Dr. Harold Feil, Cleveland.

March 9—"Management of Gastric Tumors," Dr. George T. Pack, New York City.

April 13—"Increasing Responsibilities of Anesthesiology," Dr. Ralph M. Towell, Hartford, Conn.

May 11—"The Cytopenic State," Dr. Charles A. Doan, Columbus.

Physicians, interns and graduate nurses are invited to attend. Additional information may be obtained from Dr. Edward B. Weinman, secretary-treasurer, National Exchange Bank Building, Steubenville.

This is the eighth season for the Fort Steuben Academy of Medicine. The Academy is comprised of members of the county medical societies in the tri-state adjoining areas of Pennsylvania, West Virginia and Ohio. It was organized to bring top men of medicine into the area.

Dr. Jonathan Forman, Editor of *The Journal*, was dinner speaker at the thirty-fourth annual meeting of the Ohio Society for Crippled Children, held October 17-18 in the Deshler-Hilton Hotel, Columbus. His subject was "Human Conservation and Child Safety."

State-Wide TV Program "Prescription For Living" Is Presented Again

"Prescription for Living," the state-wide TV program originating in Cleveland that proved so popular last year, again is being presented this year over a period of 17 weeks.

The programs are brought to the public by the Standard Oil Company of Ohio (Sohio) in cooperation with the Cleveland Academy of Medicine, the Cleveland Health Museum and leading doctors from other areas. The programs are broadcast on Sunday afternoons beginning at 1 o'clock.

The following stations throughout the State will carry the programs through a special network hookup: WXEL, Cleveland; WTVN, Columbus; WKRC, Cincinnati; WHIO, Dayton; WSPD, Toledo; WKBN, Youngstown; and WHIZ, Zanesville.

Three programs were held during October. Additional ones are scheduled through January.

In line with the format of the former series, the adventures of the health-minded Hampton family stimulates discussion between the program host and his guest medical authority. Printed digests of each telecast are available free from the Cleveland Health Museum, 8911 Euclid Ave., Cleveland 6, Ohio.

The tentative schedule, announced at the beginning of the series, is as follows (guest physicians are from Cleveland unless otherwise stated):

October 11—Wonder Drugs—Dr. Charles Higley.

October 18—Coronary Disease — Dr. Maurice Schnitker, Toledo.

October 25—Toxicology—Dr. Alan Moritz and Dr. Irving Sunshine.

November 1—Diabetes—Dr. M. I. Sparks.

November 8—Hearing—Dr. Charles Kinney.

November 15—Children's Diseases—Dr. James Kramer, Akron.

November 22—Nutrition—Dr. George Bidder.

November 29—Worry—Dr. Edward Harper.

December 6—Control of Pain—Dr. R. J. Whitacre.

December 13—Rheumatic Fever—Dr. Charles Rammelkamp.

December 20—Conquering Worry—Dr. Oscar Markey.

December 27—What We Know About Alcohol —Dr. Francis Bayless.

January 3—Sinus, Tonsils, Adenoids—Dr. Paul Moore.

January 10—Anemia—Dr. Charles A. Doan, Columbus.

January 17—Gall Bladder—Dr. John Budd.

January 24—Virus X—Dr. John Dingle.

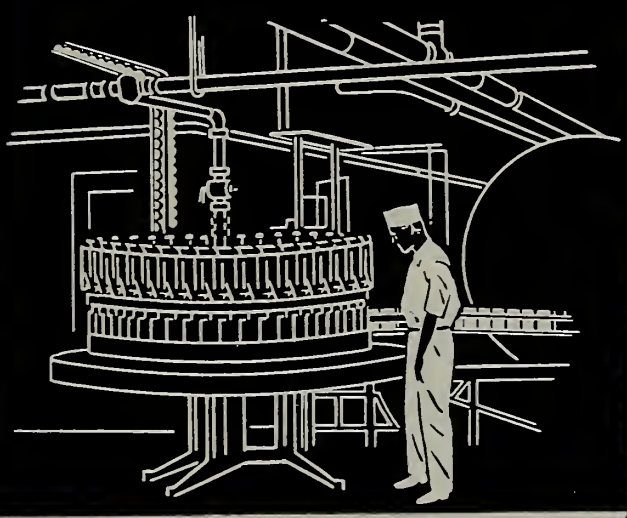
January 31—Stomach—Dr. Leon Schiff, Cincinnati.

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Baker's Modified Milk is made from Grade A Milk (U. S. Public Health Service Milk Code), which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of carbohydrates, vitamins and iron.

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*Cheadle—*Artificial Feeding and Food Disorders of Infants*, Sixth Edition (1906)

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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

County and State Lay Executives Discuss Common Problems



This get-together in the headquarters office of the State Association shows executive secretaries of metropolitan county societies as they met with members of the O. S. M. A. staff. Clockwise around the table are: Stanley Mauck, Columbus Academy; Mrs. Betty Weaver, Summit County; Mrs. Mary B. Herald, Mahoning County; Charles G. Grieg, (extreme left of photo), Butler County; Robert F. Freeman, Montgomery County; George H. Saville, public relations director for the State Association; Robert W. Elwell, Toledo Academy; Charles S. Nelson, Executive Secretary of the State Association; John Hanni, Cleveland Academy; Edward F. Willenborg, Cincinnati Academy; H. Van Y. Caldwell, Cleveland Academy; and E. M. Sprunger, Stark County. Also present were Hart Page and Gordon Moore of the State Association and the entire staff of the Columbus office. The conference was held on September 25 and 26 in the Columbus office.

Office Public Relations for the Busy Physician

The following is abstracted from an address by Mr. Stanley R. Mauck, Executive Secretary of the Columbus Academy of Medicine, at the Fourth Annual Medical Public Relations Conference of the American Medical Association, Los Angeles, December, 1951.

SELECTING A COLLECTION AGENCY

The judicious use of a responsible collection service is advisable not only to protect the doctor's financial interest, but also in fairness to the conscientious debtor who pays satisfactorily. How, then, should an agency be selected so that the vital public relations factor can be protected in this delicate service?

There is much to be said for the professionally-controlled business bureau—particularly those rendering multiple business services. One of the very great assets is its ability to do a professional relations job in every service rendered.

Where neither professionally-controlled bureaus nor approved private agencies are available, what, then, are the doctors to do about their bad accounts? Obviously, it is up to the individual doctor to select an independent collection service which he believes will most nearly handle the accounts in the right manner.

YARDSTICK FOR AGENCIES

Here are a few precautions:

(1) Select a local agency with a reputation for reliability and good standing in the community.

(2) Avoid out-of-state and mail order-type agencies.

(3) Investigate the methods used. (Ask to see the type of first notice and follow-up material.)

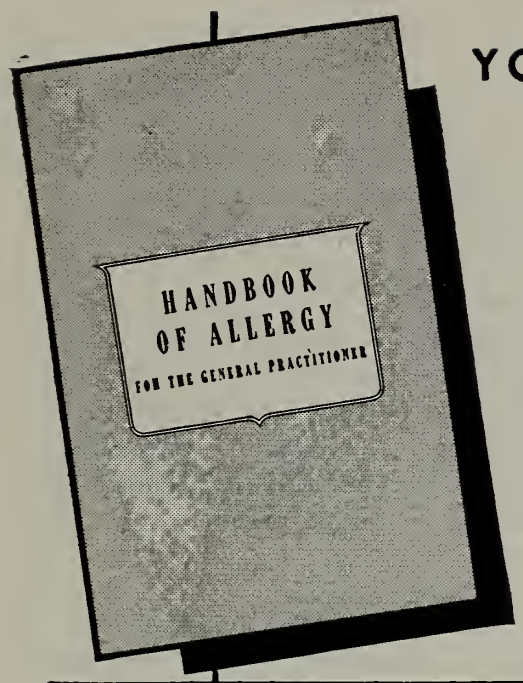
(4) Check up on the ownership and financial responsibility of the agency and its promptness in settling for money collected.

(5) As a general rule, don't sign a contract—better agencies seldom use them.

(6) Can you be assured that no legal action, or threat of such, will be taken without your consent?

(7) Will the agency be governed by your instructions to collect only within the scope of good public relations?

(8) Will it agree to report cases deserving your special consideration and accept adjustment, withdrawal or cancellation of an account when, in your opinion, such action is advisable in the interest of good public relations?



YOUR RESPONSIBILITY FOR ALLERGY CARE . . .

Allergy must be considered in the differential diagnosis of virtually every disease.

BARRY LABORATORIES' new "Handbook of Allergy for the General Practitioner" will convince you how easy it is for every physician to fulfill his responsibility for effective allergy care.

SIMPLE TECHNIQUE. Now you can have a step-by-step guide to the diagnosis and treatment of all common diseases of allergy.

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Cedar 1-4097

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MEDICAL DIRECTOR: NEIL T. MCDERMOTT, M. D.

In Memoriam . . .

Wilbert C. Bateman, M.D., Zanesville; Starling Medical College, Columbus, 1897; aged 86; died August 29; member of the Ohio State Medical Association through 1941. Dr. Bateman served all of his professional career in Zanesville and had been honored with the 50-Year Pin of the Ohio State Medical Association. In addition to his medical practice, he was identified with many civic undertakings. He served on the city board of education from 1923 to 1941, was a city health officer and served on the city charter commission about 30 years ago. He was surgeon for the B. & O. Railroad and served as examiner for several insurance companies; was a member of the Methodist Church. Surviving are two daughters and two sons, Dr. Roland D. Bateman, of Zanesville, and Dr. Edwin J. Bateman, of Pittsburgh; also two sisters and a brother.

Emery Alvin Bechtol, M.D., Montpelier; Michigan College of Medicine and Surgery, Detroit, 1892; aged 83; died September 14. Dr. Bechtol practiced his profession for a total of 58 years in Williams County before his retirement about three years ago. He was in Ainger until 1922, when he moved to Montpelier. During World War I, Dr. Bechtol served with the Army Medical Corps. Survivors include two sons and a daughter.

Ruth G. Bernheim, M.D., Cincinnati; Laura Memorial Woman's Medical College, Cincinnati, 1902; aged 73; died September 12; member of the Ohio State Medical Association through 1950. A pioneer woman doctor of Cincinnati and in practice for many years before her retirement, Dr. Bernheim had been honored with the 50-Year Pin of the Ohio State Medical Association. Survivors include three sisters and a brother.

Thomas R. Biddle, M.D., Athens; Medical College of Ohio, Cincinnati, 1892; aged 89; died September 10. Dr. Biddle practiced for about 10 years in Athens before he discontinued practice and went into the coal business. One of seven brothers, all of whom became physicians, Dr. Biddle is survived by three of them in Ohio—Dr. David H. Biddle, Athens; Dr. A. C. Biddle, Mansfield, and Dr. Benjamin Biddle, Lancaster. He is also survived by his widow, a daughter-in-law and five grandchildren.

Harold M. Gilmore, M.D., Worthington; Ohio State University College of Medicine, 1921; aged 58; died September 11; member of the Ohio State Medical Association; member of the American Medical Association; member of the American Society of Anesthesiologists. Dr. Gilmore maintained his office in Columbus for many years and was physician in charge of anesthesia at Mt. Carmel Hospital. He was a member of the Masonic Lodge, Alpha Kappa Kappa and Pi Kappa Alpha. His widow and a son survive.

Kenneth E. Greenwalt, M.D., Canton; Ohio State University College of Medicine, 1929; aged 49; died September 24; member of the Ohio State Medical Association. Dr. Greenwalt served all of his professional career in Canton. Affiliations included membership in the Methodist Church. Surviving are his widow, a daughter, a son, his mother and a sister.

T. Victor Kolb, M.D., Litchfield; Ohio State University College of Medicine, 1934; aged 49; died September 20; member of the Ohio State Medical Association; member of the American Medical Association; president of the Medina County Medical Society, 1951-1952 and its vice-president the previous term; also an alternate delegate, and active on numerous committees of the local Society. Upon completion of his college training, Dr. Kolb interned at St. Francis Hospital and did residency work at Children's Hospital, both in Columbus. He then set up private practice in South Charleston. He entered Medical Corps service in 1940 and later went overseas with the 37th Division, attaining the rank of major. After serving with the Crile Veterans Administration Hospital, Cleveland, for a short time, Dr. Kolb went into private practice in Litchfield in 1945. Affiliations included memberships in Alpha Sigma Phi, Alpha Kappa Kappa, the Masonic Lodge, Inominatium Club of Cleveland, Western Reserve Matinee Club, Leroy Country Club, the Rotary Club, Veterans of Foreign Wars, the American Legion and the Congregational Church. Surviving are his widow, two daughters, his father and two brothers.

George W. Magargee, M.D., Medina; Western Reserve University College of Medicine, 1904; aged 76; died September 30. Dr. Magargee practiced for many years in the Cleveland area before moving to Medina about 10 years ago. He had been retired for about seven years. Surviving are his widow, two sons, a sister and four brothers.

Bernard A. Maloney, M.D., Upper Sandusky; Starling Medical College, Columbus, 1907; aged 71; died October 6; member of the Ohio State Medical Association; member of the American Medical Association; president of the Wyandot County Medical Society from 1930 to 1938, its secretary, 1928-1929, and delegate for several terms; also active on several local committees. Dr. Maloney practiced his profession for more than 40 years in Upper Sandusky. He was a pioneer in the organization of the Wyandot Me-

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Testosterone Cyclopentylpropionate .....50 mg. or 100 mg.
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50 mg. per cc. available in 10 cc. vials

100 mg. per cc. available in 1 cc. and 10 cc. vials

The Upjohn Company, Kalamazoo, Michigan



morial Hospital and served as a member of its board of governors. He was a member of the Catholic Church and for 30 years served as state medical director for the Knights of Columbus. He is survived by four daughters, a brother and two sisters.

James E. Miller, M.D., Steubenville; University of Pittsburgh College of Medicine, 1894; aged 84; died September 1; member of the Ohio State Medical Association through 1951. Dr. Miller began his practice in Richmond, later moved to Cadiz and in 1901 moved to Steubenville. During World War I, he served in the Medical Corps. He was a member of the Masonic Lodge, and was an elder in the Presbyterian Church. One brother survives.

James E. Patton, M.D., Cambridge; Starling Medical College, Columbus, 1903; aged 79; died October 7; member of the Ohio State Medical Association; member of the American Medical Association; vice-president of the Guernsey County Medical Society in 1944. Dr. Patton practiced his profession in Cambridge and Byesville for fifty years and last spring was given the 50-Year Pin of the Ohio State Medical Association. He held memberships in the Masonic Lodge, the Odd Fellows and the United Presbyterian Church. Survivors include his widow and a daughter.

Charles Tabb Pearce, M.D., Cincinnati; New York University Medical College, 1892; aged 82; died September 21; member of the Ohio State Medical Association. Dr. Pearce served all of his professional career in Cincinnati, retiring about 10 years ago. He served as professor of dermatology at the former Cincinnati College of Medicine and Surgery. Memberships included several Masonic bodies and the Cincinnati Club. Surviving are his widow, a son and a sister.

John Alan Riebel, M.D. Kingsville, Texas; Ohio State University College of Medicine, 1934; aged 46; died in early September; former member of the Ohio State Medical Association. Dr. Riebel practiced medicine for a number of years in Ashville both before and after the war. From 1941 to 1945 he was in the Army Medical Corps where he attained the rank of Lieutenant Colonel. He also practiced for a short time in Columbus before moving to Texas. Surviving are his widow, two daughters and a brother, Dr. Frank A. Riebel, of Columbus.

Harry W. Shaw, M.D., New Lexington; Starling Medical College, Columbus, 1898; aged 79; died September 15; member of the Ohio State Medical Association; president of the Perry County Medical Society in 1922; vice-president in 1931 and 1942. Dr. Shaw practiced a total of 55 years and was a recipient of the 50-Year Pin of the Ohio State Medical Association. He began his practice in Gallipolis, later moved to Junction City and in 1920 moved to New Lexington. Dr. Shaw was attending physician for the Ohio Penitentiary at New Lexington and for the National Guard unit there. During World War I, he served in the Medical Corps and was a member of the American Legion. Survivors include his widow and a daughter.

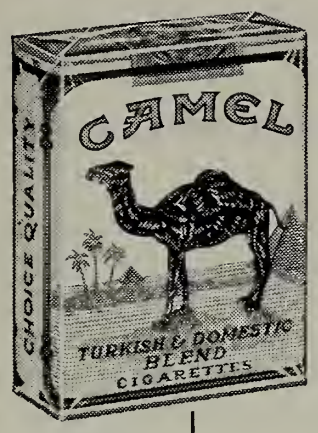
Burton O. Sours, M.D., Akron; Ohio State University College of Medicine, 1927; aged 59; died September 24; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Sours served all of his professional career in Akron. In addition to his practice, he was active in numerous civic and fraternal organizations; was a member of Nu Sigma Nu, several Masonic bodies and the Akron University Club. Surviving are his widow, a stepson, a stepdaughter, and three brothers.

Henry Stanbery, M.D., Cincinnati; Miami Medical College, Cincinnati, 1899; aged 80; died September 2; member of the Ohio State Medical Association through 1949; member of the American Academy of Ophthalmology and Oto-Laryngology. After receiving his medical degree, Dr. Stanbery did postgraduate work at Johns Hopkins and the New York Eye and Ear Infirmary. He started practice in Cincinnati in 1906 and continued until 1949 when he retired. During World War I, he served overseas with the Medical Corps. Affiliations included memberships in Alpha Kappa Kappa, Psi Upsilon and the Military Order of the Loyal Legion. Survivors include his widow and two brothers.

Jesse E. Thompson, M.D., Bristolville; Western Reserve University School of Medicine, 1904; aged 76; died October 4; former member of the Ohio State Medical Association, last in 1945. A life resident of Trumbull County, Dr. Thompson had practiced for 42 years before he retired eight years ago. He practiced both at Bristolville and in Warren, returning to Bristolville upon his retirement. During World War I, Dr. Thompson served with the Army Medical Corps. Survivors include his widow, a son and two brothers.

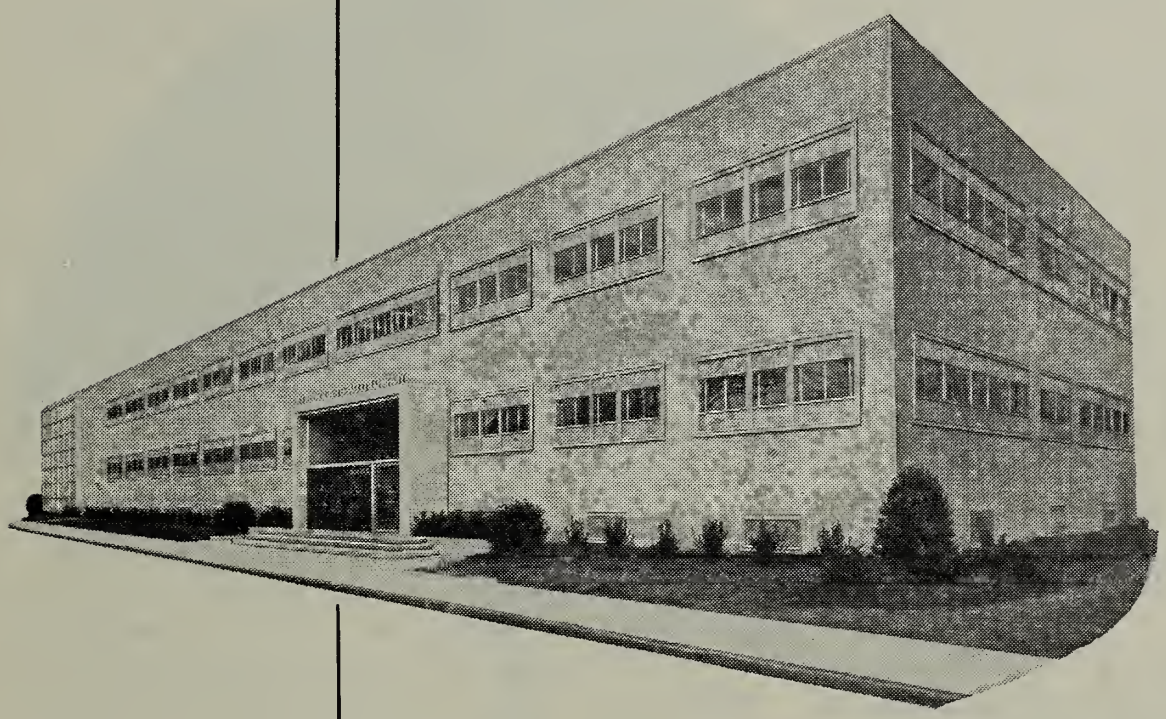
William T. Ungard, M.D., Xenia; University of Cincinnati College of Medicine, 1927; aged 56; died September 11; member of the Ohio State Medical Association; member of the American Medical Association; a former secretary of the Greene County Medical Society, he also served as vice-president and president and was active on several committees. A practicing physician in Xenia for 26 years, Dr. Ungard was chief of the Department of Obstetrics at Greene Memorial Hospital. He was a member of the Presbyterian Church. Surviving are his widow, three sons, four brothers and six sisters.

FORTY YEARS OF



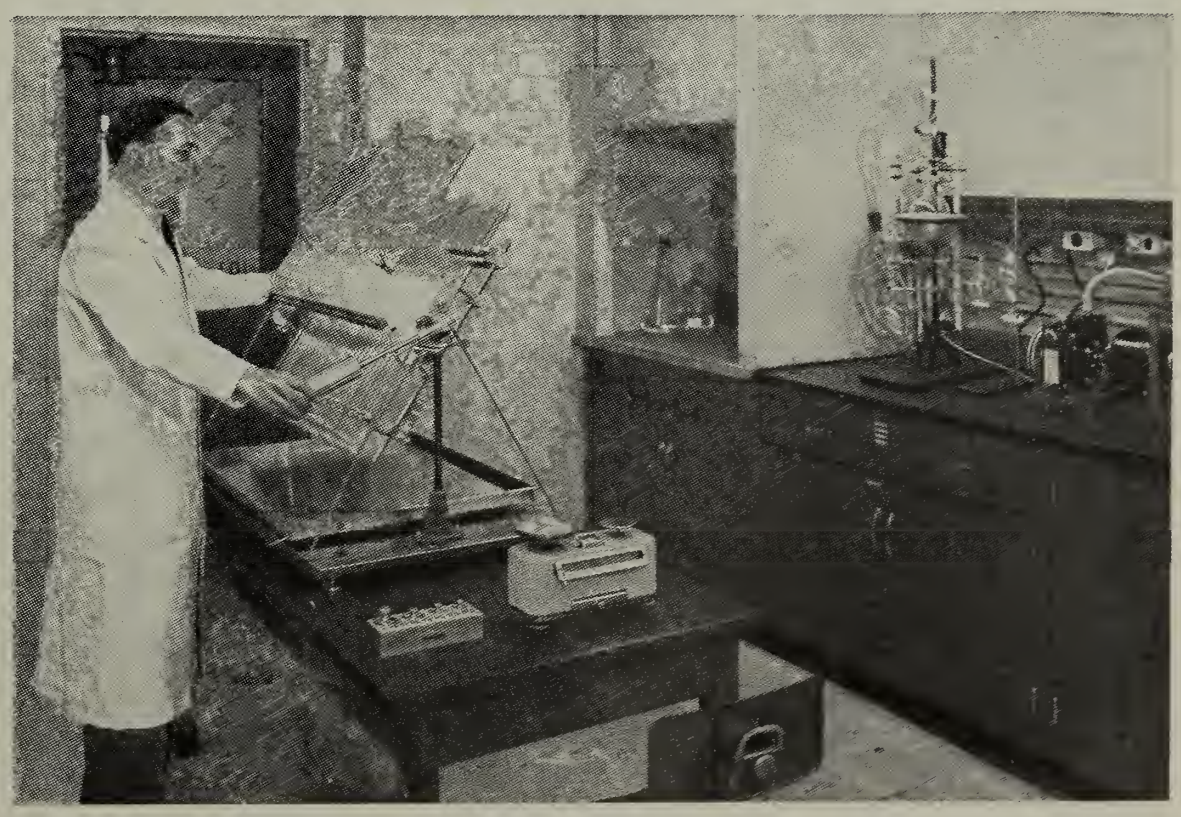
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Things Medical Writers Shouldn't Do . . .

Some Snappy Suggestions Offered by Dr. Walter C. Alvarez As Guide To Physician-Journalists At Medical Writers Association Symposium

AT A SYMPOSIUM on medical writing sponsored by the American Medical Writers Association in St. Louis, Dr. Walter C. Alvarez, editor-in-chief of *Modern Medicine*, medical columnist, and an emeritus member of the Mayo Clinic staff, made a talk about some of the things which medical writers shouldn't do.

Since the address contained a lot of gems, *The Journal* is taking the liberty of reproducing the speech herewith with a recommendation that it be digested thoroughly by Ohio physicians who make contributions to medical magazines or who have the desire to do so. The remarks by Dr. Alvarez were published originally in the *Mississippi Valley Medical Journal.*

* * * *

As an editor I often wish that writers would jump right into their subject and leave out their long preamble. Many a time I have written a man to tell him I would take his paper if he would let me begin "half-way down page 4":

In most papers a long survey of the literature should be left out. The writer would do better to say that a good summary of the literature on the subject has been published by John Doe in a certain journal.

I wish writers would avoid losing their readers' interest by inserting near the beginning of their paper a page or two on technic. I would prefer to see such details delegated to an appendix at the end of the article. There they can be consulted by those few men who may want some day to repeat the experiments or to study them in detail.

Often, when I see a paper on some hackneyed subject such as the electrocardiogram or gastric acidity I wish the writer had begun by telling me why he thought he was justified in writing. Had he found some gap in our knowledge on the subject and did he think he had filled it? I would like him in some such way instantly to grip my interest and make me want to read the article.

For instance, I recently saw an article on the bundle of His. Probably, when the editor first saw it he said to himself, "For goodness sake, what on earth does a man think he can contribute now to that old subject which was worked out pretty well by Tawara and others, back in 1907?" But then I am sure his interest was gripped when he read the writer's opening statement to the effect that for years he had been cutting serial sections of human hearts trying to find the "bundle" and, so far, he hadn't been able to find it! That was a good beginning for his article.

Another thing that medical editors crave is a shortening of case reports. Most such reports are needlessly padded with unimportant details which have no bearing on the topic under discussion. A doctor will often supply the complete report of an autopsy, when all he needed to say was that the only significant finding was a ruptured aneurysm of the circle of Willis or a thrombosis of the mesenteric vein.

LONG WORDS AND SENTENCES

Most of us editors wish, also, that writers would avoid unnecessarily long words and long cumbersome sentences. As my old general practitioner father used to say to me, when he came in off the road around ten o'clock at night, and got in bed to read for a half-hour, his brain was too tired to grasp highly involved sentences and long words.

I have found that I can write about practically anything in medicine, using such simple Anglo-Saxon words that the average intelligent laymen can understand what I am saying. Some few doctors and editors have told me that this isn't dignified or ethical, and once an editor even refused to take a paper of mine because he said it could be read and understood by a layman! But I think most doctors are grateful for easily understandable writing. They do not prefer the word 'singultus' to 'hiccup', or emesis to vomiting.

INVOLVED ARRANGEMENT

I hate a paper with such a poor arrangement that I have to read it through twice to understand it. Material which I needed to make a statement on page 3 intelligible or convincing to me I found on page 6. I maintain that the supplementary information should have been placed on page 3 where it would immediately have answered the questions and doubts that rose in my mind. I remember papers in which the man said on page 2 that he had used animals, but I had to read ahead to page 7 before I found that he had used dogs, or that they were anesthetized or not anesthetized. Often the writer can avoid this sort of thing only by getting someone to read his manuscript; someone who is not acquainted with the work as it was done.

I greatly wish that more writers would describe carefully and accurately and vividly what

Pneumonia weather...

the season

for bacterial

respiratory tract

infections



a time

for...

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they have done and seen and found, and then leave out the pages they love to write on theories as to the cause. I am distressed by that omnipresent doctor who thinks he can explain everything in medicine on the basis of quirks in the actions of the sympathetic and the parasympathetic. Read his stuff and you'll see that he doesn't even know the difference between these two parts of the autonomic nervous system. I am sure that for the life of him he couldn't define the parasympathetic or tell which nerves belong in that system.

TOO MUCH THEORY

I often think how wonderful the literature of the ancient Greek doctors might have been if they had only described accurately a case or two of peptic ulcer or migraine or gonorrhea or rheumatoid arthritis or brain tumor. They must have seen such cases a thousand times. But no; they wrote a few sentences of description and then several pages of explanation of the symptoms on the basis of hot and cold or moist and dry or phlegm or black bile. Our long articles on theory will doubtless look just as silly and futile to the doctors of 2500 A.D. But in that day a few good papers, now being filled with facts of observation, may still be read as classics.

I like to see in an article bits of human interest and even bits of humor. They make a paper more interesting and vivid.

REWRITING

I think it well often to put a paper away for a month or two or even a year or two. I commonly do this, and when I take it out again I can see so easily where it was poorly written and poorly arranged. I rewrite it and rearrange it, and then I may put it away again for a couple of months or so. The other day I took out of storage a paper I finished for publication some 8 years ago. It was pretty bad, and now I am editing it as heartlessly as if it had been written by a stranger.

Always, after one of my papers looks pretty good to me, I go over it and rip out every unnecessary adjective or adverb and every unnecessary sentence. Sometimes I can find even a paragraph that can be left out. We all know some writers who ought to leave out most of their paragraphs.

LET SOMEONE CRITICIZE IT

A valuable thing that many a man can do with his paper is to try it out on his wife or some other lay person. When my wife says she can't understand something I have written, I keep rewriting it until she says it is clear to her. Often she asks, "Why don't you write it as you just explained it to me?" I do that and then it is intelligible.

Many a doctor has said to me, "Why go to all that work of re-writing? I write to please myself." And my answer is, "If you are going to go to all the labor of writing why not do it so that many will read your paper?" If the article is brief and interesting, and perhaps even charming, it will be widely read. If it is too long, that one fact will greatly limit the number of readers. If it is uninteresting or hard to read, most men will skip it after looking at a page or two.

Another reason for always writing as interestingly as possible is that eventually there will be thousands of doctors in the country who, on seeing your name at the head of an article, will always start to read it. They will say to themselves, "That fellow always has something to say and says it well. Let's see what he has now."

New Members of O.S.M.A.

The following are the names of new members of the Ohio State Medical Association since Sept. 11, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ASHTABULA COUNTY
Suttles, Charles M., Ashtabula

CLARK COUNTY
Williamson, William B., Springfield

CUYAHOGA COUNTY
Benua, Richard S., Cleveland
Boaz, Willard D., Cleveland
Bowman, James A., Jr., Cleveland
Curtiss, Paul H., Jr., Cleveland
Driver, Maier M., Cleveland
Gilger, Anita P., Cleveland
Gore, Jay C., Bedford
Hudack, Stephen S., Cleveland
Kenny, John A., Jr., Cleveland
Kleinman, Albert N., Cleveland
Kolcsey, Laszlo, Cleveland
Lindsay, Samuel C., Cleveland
MacKay, James A., Euclid
Moore, Richard D., Chagrin Falls
Moore, William R., Cleveland
Roberts, George A., Cleveland
Siegler, Edward E., Cleveland
Thomas, Royal M., Cleveland
Thomay, Wilbert S., Cleveland
Ukmar, Leopold, Cleveland
Weinstein, Fay B., Cleveland

GUERNSEY COUNTY
Balciunas, Jurgis, Cambridge

HAMILTON COUNTY
Baker, Robert E., Cincinnati
Block, Stanley L., Cincinnati
Bradford, R. Tully, Chicago, Ill.
Dobur, Walerian, Cincinnati
Lippert, Raymond J., Cincinnati
O'Shaughnessy, Robert P., Cincinnati
Steele, John L., Loveland
Whittaker, Dorothy J., Cincinnati

JACKSON COUNTY
Damron, John R., Jackson
Hood, Steve E., Jr., Jackson
Long, Harold W., Jackson

LAWRENCE COUNTY
Webster, Dan J., Ironton

LUCAS COUNTY
Newton, Anna May, Toledo

MEDINA COUNTY
Ernst, E. A., Lodi
Johnson, Myra L., Wadsworth
Wallace, John E., Jr., Wadsworth

MONTGOMERY COUNTY
Johnson, Maurine P., Dayton

ROSS COUNTY
Berno, Jack C., Chillicothe

SUMMIT COUNTY
Casto, Charles E., Cuyahoga Falls
Fairweather, William H., Akron
Phillips, Leonard V., Akron
Rees, Robert M., Akron

TRUMBULL COUNTY
Logan, Joseph L., Warren

UNION COUNTY
Sampsel, James W., Marysville

VINTON COUNTY
Johnson, Arthur J., McArthur

WASHINGTON COUNTY
Ash, Clarence E., Marietta

Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

BUTLER

The Butler County Medical Society has announced appointment of a lay executive secretary who will work on a part-time basis. He is Mr. Charles G. Greig, of Hamilton, who is also secretary of the Butler County Tuberculosis Association.

The subject, "Responsibilities of the Medical Profession in Civil Defense," was discussed at the September 30 meeting by Anthony B. Borowski, Dr. P. H., chief of the Division of Hospital Facilities of the Ohio Department of Health.

Because of the resignation of Dr. Robert Dunn, secretary-elect for 1954, the executive committee elected Dr. William Neel to fill that post.

CLINTON

The Clinton County Medical Society members and their wives held their annual dinner meeting at the Snow Hill Club on September 2. A business meeting, social evening and bingo party followed.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

DARKE

A joint meeting of the Darke County Medical Society and Auxiliary was held at the Wiebusch Manor, Greenville, on September 15, with Glenn H. Isenbarger, educator, humorist and philosopher of Springfield, as guest speaker.

The subject, "Clinical and Laboratory Aspects of Potassium Metabolism," was discussed by Dr. John D. Stapleton, Richmond, Ind., at the October 20 meeting of the Society in Greenville.

GREENE

At the October 8 meeting of the Greene County Medical Society in Greene Memorial Hospital, Xenia, Dr. Kenneth R. Arn, Dayton, discussed, "Creatinine Clearance."

MONTGOMERY

The Montgomery County Medical Society was host to the Second District meeting held in Dayton on October 2.

The Society has announced a course for doctors' receptionists, secretaries, and office nurses on office public relations, telephone techniques, office business procedure, collections, tax forms, etc., beginning in October with three sessions.

Third District

(COUNCILOR: JAMES R. JARVIS, VAN WERT)

VAN WERT

Dr. F. C. Duckwall, of Van Wert, was honored by a special dinner meeting of the Van Wert County Medical Society. The occasion was the celebration of Dr. Duckwall's 50 years of service in his profession in the county. About 30 doctors and their wives were present, with some dentists who were guests.

Dr. S. A. Edwards gave an address in honor of Dr. Duckwall and read an original poem commemorating the event.

Dr. Duckwall's son, Dr. Vernon Duckwall, of Elkins, W. Va., was present for the occasion and pinned the 50-Year Award of the Ohio State Medical Association on his father.

Dr. R. H. Good, president of the Society, presided at the meeting arrangements for which had been made by a special committee consisting of Dr. and Mrs. J. R. Jarvis, Dr. and Mrs. Robert Ayres and Dr. and Mrs. F. A. McCammon.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The following program features were announced for the Academy of Medicine of Toledo and Lucas County for October:

October 2—General meeting—"Can the Voluntary Plans Succeed?" by a panel of members of the Blue Cross-Blue Shield Medical Advisory Committee.

October 9—General Practice Section—Symposium on Diabetes, panel discussion with Dr. D. C. Frick, as moderator.

October 14—Combined meeting with Northwestern Ohio Medical Association in the Academy Building.

October 21-22—Postgraduate Lecture Series, Dr. Carl A. Moyer, St. Louis, Mo., as guest speaker.

October 23—Surgical Section—"Carcinoma of the Lung," Dr. Cranston W. Holman, New York City.

October 30—Specialty Section—"Ophthalmology in General Practice, Dr. Albert D. Ruedemann, Detroit, Mich.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland's regular meeting was held on October 16 with the following afternoon and evening program:

"The Insurance Man's Angle on Accidents," Mr. George J. Usher.

"The Management of Minor Injuries," Dr. William C. Downing.

(Continued on page 1046)

Conclusive evidence

of the effectiveness and low toxicity

of Furadantin

in treating bacterial urinary tract infections

is provided in its recent

acceptance by the Council



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brand of nitrofurantoin

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The N.N.R. monograph on Furadantin states:

"**Nitrofurantoin.—Furadantin (Eaton).—**

Actions and Uses.—Nitrofurantoin, a nitrofuran derivative, exhibits a wide spectrum of antibacterial activity against both gram-positive and gram-negative micro-organisms. It is bacteriostatic and may be bactericidal to the majority of strains of Escherichia coli, Micrococcus (Staphylococcus) pyogenes albus and aureus, Streptococcus pyogenes, Aerobacter aerogenes, and Paracolobactrum species. The drug is less effective against Proteus vulgaris, Pseudomonas aeruginosa, Alcaligenes faecalis, and Corynebacterium species; many strains of these organisms may be resistant to it. However, bacterial resistance to other anti-infective agents is not usually accompanied by increase in resistance of the organisms to nitrofurantoin. The drug does not inhibit fungi or viruses.

Nitrofurantoin is useful by oral administration for the treatment of bacterial infections of the urinary tract and is indicated in pyelonephritis, pyelitis, and cystitis caused by bacteria sensitive to the drug. It is not intended to replace surgery when mechanical obstruction or stasis is present. Following oral administration, approximately 40% is excreted unchanged in the urine. The remainder is apparently catabolized by various body tissues into inactive, brownish compounds that may tint the urine. Only negligible amounts of the drug are recovered from the feces. Urinary excretion is sufficiently rapid to require administration of the drug at four to six hour intervals to maintain antibacterial concentration. The low oral dosage necessary to maintain an effective urinary concentration is not associated with detectable blood levels. The high solubility of nitrofurantoin, even in acid urine, and the low dosage required diminish the likelihood of crystalluria.

Nitrofurantoin has a low toxicity. With oral administration it occasionally produces nausea and emesis; however, these reactions may be obviated by slight reduction in dosage. An occasional case of sensitization has been noted, consisting of a diffuse erythematous maculopapular eruption of the skin. This has been readily controlled by discontinuing administration of the drug. Animal studies, using large doses administered over a prolonged period, have revealed a decrease in the maturation of spermatozoa, but this effect is reversible following discontinuance of the drug. Until more is known concerning its long-term effects, blood cell studies should be made during therapy. Frequent or prolonged treatment is not advised until the drug has received more widespread study. It is otherwise contraindicated in the presence of anuria, oliguria, or severe renal damage.

Dosage.—Nitrofurantoin is administered orally in an average total daily dosage of 5 to 8 mg. per kilogram (2.2 to 3.6 mg. per pound) of body weight. One-fourth of this amount is administered four times daily—with each meal and with food at bedtime to prevent or minimize nausea. For refractory infections such as Proteus and Pseudomonas species, total daily dosage may be increased to a maximum of 10 mg. per kilogram (4.5 mg. per pound) of body weight. If nausea is severe, the dosage may be reduced. Medication should be continued for at least three days after sterility of the urine is achieved."

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"The Choice of Anesthesia in Trauma," Drs. R. A. Hingson, D. E. Hale, H. E. Kretchmer and H. S. Davis.

"Emergency Roentgenographs in Acute Trauma," Dr. Norman M. Glazer.

"The Repair of Tendons Lacerated in Critical Areas," R. H. Segnitz.

"The Management of Minor and Major Burns," Dr. F. A. Simeone.

"Recent Advances in the Use of Plasma Expanders," Lt. Col. Edwin J. Pulaski, M.C.

Evening meeting — "Lessons from Korea in Management of Trauma," Dr. John M. Howard, assistant professor of surgery, Baylor University College of Medicine, and director of the Surgical Research Team in Korea.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

Three doctors were honored by the Summit County Medical Society at the September 23 meeting at the Portage Country Club, Akron, by being presented 50-Year Pins of the Ohio State Medical Association.

They are Dr. Earl Z. Alspach, Akron, Dr. William X. Taylor, Cuyahoga Falls, and Dr. Eugene B. Pierce, formerly of Akron but now living in Florida.

Approximately 465 doctors and their wives attended the annual all-day outing and dinner. Dr. C. A. Gustafson, Younstown, Councilor of the Sixth District, made the presentations in behalf of the State Association.

Dr. William Skipp, Youngstown, chairman of the Ohio Committee of the American Medical Education Foundation, discussed the work of the Foundation.

Mr. Robert Freeman, Dayton, executive secretary of the Montgomery County Medical Society, spoke on the subject, "Advantages and Functions of a County Medical Society Executive Secretary," at the October 6 meeting.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

"The Short of Breath Patient," was the subject discussed by Dr. David G. Gillespie, Cleveland, at the October 15 meeting of the Belmont County Medical Society in Bellaire City Hospital.

TUSCARAWAS

Dr. Salvatore Sancetta, of City Hospital, Cleveland, discussed the latest developments in the diagnosis and treatment of pathological heart conditions at the October 8 meeting of the Tuscarawas County Medical Society in Dover.

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

FAIRFIELD

Two local doctors were honored at the October 13 meeting of the Fairfield County Medical Society at which time they were presented 50-Year Pins of the Ohio State Medical Association. They are Dr. John W. Whittus, of Baltimore, and Dr. Pinckney S. Bone, Lancaster. Making the presentations in the name of the Association was Dr. Robert S. Martin, Zanesville, Eighth District Councilor.

Dr. Leo Sapirstein of the Ohio State University College of Medicine discussed the subject of hypertension for the scientific program.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. Harry Shirkey, Cincinnati, spoke on the subject, "Common Poisonings in Children," at the September 14 meeting of the Scioto County Medical Society in the Portsmouth General Hospital Nurses Home.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Subject for the October 19 meeting of the Columbus Academy of Medicine was "Some Chemical Factors in the Pathogenesis of Atherosclerosis," discussed by Dr. David P. Barr, clinical teacher at Cornell.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

Dr. Merrill D. Prugh, Dayton, President-Elect of the Ohio State Medical Association, was guest speaker at the September 8 meeting of the Lorain County Medical Society at the Spring Valley Country Club, Elyria. His subject was, "The Life of a Doctor."

At the October 13 meeting in the Spring Valley Country Club, Dr. William J. Feicks, Lorain, spoke on "The Psychiatric Patient."

Cincinnati—The Children's Hospital Research Foundation has received an additional two-year grant of $19,853 per year, from the U. S. Public Health Service for support of its study of dysentery and possible development of vaccines to immunize against it under direction of Dr. Merlin L. Cooper.

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A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the Ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as prostatic resection.

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Activities of Woman's Auxiliary . . .

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President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House

Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima

Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

FALL CONFERENCE

The highlight of the Fall Conference of the State Auxiliary held in September in Columbus was the luncheon given in honor of Mrs. William J. Gillette of Toledo, who was named "Medical Auxiliary Mother of the Year" by the group. Mrs. Gillette, now 89, has been active in medical affairs for over 70 years. She is the widow of the late Dr. Gillette, who founded Robinwood Hospital (now St. Luke's) and was one of Toledo's first surgeons. Four doctor sons are now prominent in Toledo and three grandsons are in the medical field also. Mrs. Gillette was the founder of the Lucas County Auxiliary.

The conference in the Fort Hayes Hotel was formally opened on the afternoon of September 28 by Mrs. N. M. Reiff, who conducted the Board meeting. Dinner followed.

Mrs. Reiff again presided at next morning's General Assembly, following which the meeting broke up into discussion groups according to the size of the Auxiliaries. Mrs. M. J. Crow, president of Warren County Auxiliary, was moderator for those interested in small communities; Mrs. George Marr, president of Butler County Auxiliary, for the medium sized communities; and Mrs. Robert H. Kotte, president of Hamilton County Auxiliary, for large sized communities.

Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, and Mr. George H. Saville, public relations director, gave talks following the luncheon, honoring Mrs. Gillette.

Mrs. A. Paul Hancuff, president-elect, conducted the meeting when reports of the moderators were given. Instructions were given by the various state chairmen to bring to a close another very successful and interesting Fall Conference.

ALLEN

The first meeting of the Auxiliary to the Academy of Medicine of Lima and Allen County was a luncheon in the Shawnee Country Club where arrangements were completed for the benefit card parties. Proceeds from the benefits go to the loan scholarship fund for nurses. Mrs. A. W. Pinkerton and Mrs. Forest Hunter are co-chairmen for these arrangements. Others on the committee are Mesdames R. C. Netherton, J. D. Albertson, R. P. Eptstein, F. G. Maurer, Sr., F. G. Maurer, Jr., V. A. Noble, V. H. Hay, G. N. King, H. A. Thomas, Harry Warshawsky, all of Lima, Mesdames Morris Borkon and R. J. Doernberg, Spencerville, and Mrs. F. D. Rodabaugh, Bluffton.

The Auxiliary has five projects for the year: Nurse loan fund and nurse recruitment; making washable slippers for patients in St. Rita's, Memorial, and District Tuberculosis Hospitals; assisting the Y. W. C. A.'s Best Years Club (geriatrics); and cooperating with the State Auxiliary.

BUTLER

A tea was given at the home of Mrs. Edward Keating in Hamilton for the Butler County Auxiliary. Mrs. Joseph Peil of Middletown, president, conducted the meeting. Mrs. G. E. Marr and Mrs. M. F. Vereker, presided at the tea table. Mrs. Gaston B. Hannah of Cincinnati, district director, and guest of honor, gave a talk on the purpose of the local auxiliary. Four new members were welcomed at the meeting.

CHAMPAIGN

The Auxiliary met for a luncheon and business meeting on September 25 in Millers Colonial Room. The president, Mrs. F. E. Lowry, conducted the meeting at which time the school bond issue was discussed, and it was noted to send a letter of endorsement to the Board of Education. Mrs. Lowry and Mrs. I. Miller, president-elect, attended the Fall Conference.

FAIRFIELD

Five new members were introduced by Mrs. G. S. Rodabaugh, membership chairman, at the September meeting of the Fairfield Auxiliary. Hostesses were Mrs. H. M. Amstutz, Mrs. C. F. Clark, Mrs. J. C. Beesley, and Mrs. C. Brown. A review of recent legislation was given by Mrs. J. C. Beesley.

The Auxiliary entertained the new student nurses of the Lancaster Fairfield County Hospital. This is an annual event, welcoming the young women entering training. The new students were thus honored. Games and refreshments were in charge of Mrs. J. J. Hoodlett, Mrs. W. D. Monger, Mrs. W. D. Nusbaum, Mrs. K. A. Gaines, Mrs. A. C. Essman, Mrs. G. S. Rodabaugh, and Mrs. F. E. Spangler.

FRANKLIN

Sixteen new members were welcomed at the Auxiliary's traditional smorgasbord at the Columbus Riding Club, and were introduced by

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Mrs. W. J. Miller. Mrs. Harve M. Clodfelter, the new president, conducted the meeting. Fall fashions were modeled by the doctors' wives.

The meeting was planned by Mrs. O. M. Goodloe and members of the social and telephone committees. Mrs. Luther Keith and Mrs. Joseph Gallen were in charge of the show. Music was provided by Mrs. Willis Kubiac, and the models were Mesdames H. William Clatworthy, jr., Rivington Fisher, Edwin Zartman, Joseph Gallen, Charles Harding, William H. R. Howard, Roy E. Krigbaum, John Lowery, Charles Matthews, Robert E. Pickett, E. R. Schumacher, Jack Silberstein, Trent Smith, and Jack N. Taylor.

GREENE

Mrs. N. M. Reiff, of Washington Court House, president of the State Auxiliary, was guest speaker for the Greene County Auxiliary at the September meeting. She discussed the auxiliary's theme, "To Be Well Informed On Community Functions and Affairs." Mrs. Richard F. Kelley, president, conducted the meeting.

The Auxiliary gave a reception for the ten women who were graduated from a course in practical nursing. One hundred and fifty guests attended the affair, including members of the class and their families and friends. Mrs. Paul D. Espey was chairman of the committee in charge of arrangements, and Mrs. Kelley, Mrs. T. F. Myler, and Mrs. Harold E. Ray were hostesses. Miss Louise Schroeder, registered nurse and director of the course given at Greene Memorial Hospital, presided at the reception table.

HAMILTON

Organizational policies and new projects were on the agenda of the meeting of directors and new officers of Hamilton Auxiliary held recently at the home of the president, Mrs. Robert H. Kotte. At the Fall Conference, Mrs. Kotte was in charge of the round table discussion concerning large auxiliaries. Mrs. William H. Lippert, Mrs. Paul M. Woodward, Mrs. Gaston Hannah, and Mrs. Frank Stevenson also attended the Conference.

HARDIN

The program planned for the year was given at the first fall meeting of the Auxiliary. Mrs. D. W. DeWar, president, presided, and Mrs. Glen Vanatta, of Forest, treasurer, reported cash gifts of $330 to Hardin Memorial Hospital and $334 to San Antonio.

Mrs. H. E. Gibson, chairman of program, outlined the "Know Your Community" program, the theme chosen by the committee.

Mrs. J. A. Kramer of Ada and Mrs. N. C. Schroeder were appointed by the president to attend the Fall Conference. Mrs. R. W. Stacey of Columbus was a guest of the Auxiliary.

LICKING

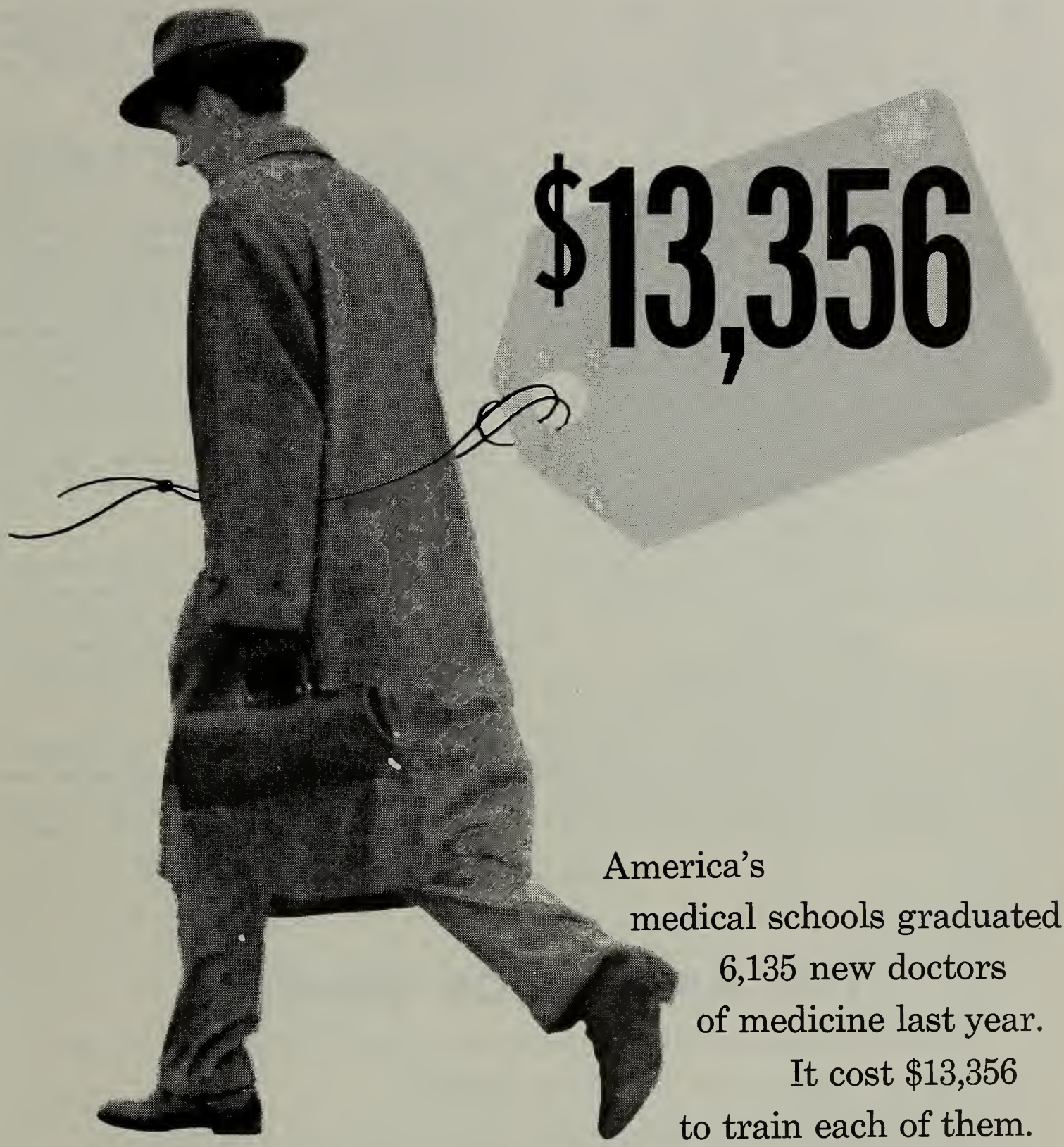
Reports of the Fall Conference were given at the first meeting of the season of the Licking County Auxiliary held in the Warden Hotel. Mrs. Carl L. Petersilge presided, and the program for the year was presented by the committee members, Mrs. Ralph Pickett, chairman, with Mrs. Kurt Fleisch, Mrs. H. A. Campbell, and Mrs. Donald Sperry. Mrs. Petersilge, Mrs. Edwin Lane, president-elect, Mrs. Ralph Pickett, vice-president, and Mrs. William Wells, nurse recruitment chairman, all attended the Fall Conference.

LUCAS

At the October meeting of the executive board, Mrs. Boni Petcoff reported on the Fall Conference. Seven members from the Auxiliary attended. They were Mrs. A. Paul Hancuff, state president-elect; Mrs. Myron Means, fourth district director; Mrs. E. Benjamin Gillette, state parliamentarian, policy committee chairman, and a past state president; Mrs. Petcoff, county president; Mrs. Edward L. Burns, county president-elect; Mrs. William J. Gillette, and Mrs. Norris W. Gillette. The group was honored by having its beloved member, Mrs. William J. Gillette, named "Medical Mother of the Year" by the State Auxiliary at the Conference.

The program for the women's activities for the Northwestern Ohio Scientific Assembly included a coffee hour in the Academy building, and a luncheon in the Tallyho Tea Room, and a punch hour in the Academy Building. Dr. H. Keith Fischer, of the Department of Psychiatry of Temple Medical School, Philadelphia, spoke after the luncheon meeting. Mrs. Joseph Hertzberg was chairman of the committee on arrangements. She was assisted by Mesdames Paul Bell, E. L. Gaspari, Gustave Link, Merl B. Smith, C. J. A. Paule, Fred P. Osgood, Wendell W. Green, John Dickie, F. V. Gipson, Oliver E. Todd, O. H. Stone, Myron G. Means, E. Forrest Ward, A. Paul Hancuff, Davis L. Friedman, E. Benjamin Gillette, Edward J. McCormick, A. D. Vogelsang, Kenneth Schoenrock, George H. Lemon, and Richard G. Hotz.

The Live Issues of Today study group met at the home of Mrs. Wendell Green. Mrs. Rollin Kuehbeler aided the hostess. Mrs. R. P. Whitehead, jr., will be hostess to the Live Issues evening study group. Mrs. Whitehead was assisted by Mrs. Jack Millis and Mrs. Max Schnitker. Mrs. Morris Selman led a discussion on election issues. The fund raising committee, of which Mrs. Harold Shapiro is chairman, was entertained at the home of Mrs. J. B. Hirsch, the co-chairman. Final plans were completed for the Halloween Masquerade Dance. Those on the committee planning the benefit are Mesdames F. V. Gipson, E. F. Glow, F. R. Canelli, Howard Murphy, Herbert C. Weller, Ernest Gottschalk, Fred M. Douglass, jr., K. C. McCarthy, Gordon



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The Auxiliary is pleased to announce that Betty Lou Griggs of Antwerp, Ohio, is the winner of the first three-year scholarship to Toledo Hospital. The scholarship is in the amount of $300.

MIAMI

The September meeting of the Auxiliary was held at the home of Mrs. E. R. Irvin in Bradford. Plans for the year were discussed, and committee reports heard. Members were thanked for helping with the Medical Society Health Display at the County Fair, and the group volunteered to help with the free chest x-rays in each community. The gift auction at each meeting was to be continued. A note of thanks was read from Dolores Winters, who won the year's scholarship to enter the College of Nursing Education, Miami Valley Hospital in Dayton.

MONTGOMERY

The Auxiliary served as hostesses for the Second Council District meeting held in Dayton in October. The group was honored in having Mrs. N. M. Reiff as guest. Dr. Merrill Prugh, Dr. P. A. Davis, President-Elect and President, respectively, of the State Association, and Dr. Edward J. McCormick, President of the A. M. A., greeted the guests at a luncheon given by the Auxiliary. Mrs. William B. Monsur, Second District Director, was very helpful in making the meeting a success.

OTTAWA

Two new members were welcomed at the opening fall meeting of the Auxiliary at the home of Mrs. George Boon.

New committee chairmen named were Mesdames Jack Witker, legislative; C. R. Wood, A. D. Miessner, program; W. R. Gibson, who is also state chairman, public relations; C. R. Wood, publicity in Port Clinton; George Boon, publicity in Oak Harbor; *Today's Health*, Robert Minnick; James Rhiel, historian; W. P. Shortridge, radio and visual education; G. R. Ley, card.

The program topic was "Gamma Globulin Treatment in Polio" and was presented by Mrs. Minnick.

PICKAWAY

The Pickaway County Auxiliary, which is also Guild I of Berger Hospital, is sponsoring a bazaar to raise funds for the new wing which is nearing completion. This Auxiliary has two student nurses on scholarships at Grant Hospital in Columbus.

RICHLAND

Miss Mildred Furry, librarian at Kingwood Center, spoke at the first fall meeting of the Auxiliary at the Westbrook Country Club. Three new members were introduced by Mrs. Robert

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Wolford, organizational chairman. Hostesses were Mrs. H. S. Wiedemer, Mrs. Russell Long, Mrs. Carl Longacher, and Mrs. Erling Smedal.

SUMMIT

The annual Membership Tea of the Auxiliary was held at the home of Mrs. Edwin Cauffield, a past president. Mrs. Walter Brown, social chairman, was assisted in planning the party by Mesdames Arthur H. Loomis, Glenn V. Hough, H. Willard Allison, H. Oliver Musser, George H. Bischoff, Carl Paternite, and A. H. Kyriakides. The chairman of hospitality, Mrs. James H. Pollock, and her committee greeted the members. Her committee consisted of Mesdames Maurice Wince, William C. Marsh, Carl T. Korsmo, Louis E. Brown, and Walter A. Hoyt, Jr.

The annual three day Hobby Show for Oldsters, co-sponsored by the Auxiliary and the United Community Council, broke all records in attendance, and in the number of exhibits. There were blue, red, and white ribbons given as awards. The "oldsters" were also allowed to take orders for their merchandise. They were served coffee with their box lunches at noon, so they were able to stay all day by their exhibits to chat with the visitors who came to see the show.

The members of the legislative committee provided motor service to the hospitalized and invalid voters of the county in the recent primary elections.

The doctors and their wives got together in September for an all day outing, dinner, program, and dancing for the Annual "Summit County Day" at the Portage Country Club. Committees from the Auxiliary made flower arrangements, and set up the program for the women.

TRUMBULL

The Medical Society and Auxiliary held a joint meeting at Squaw Creek Country Club in September. Dr. E. P. Buchanan, professor of surgery at the University of Pittsburgh, was the principal speaker and his topic was "Cancer of the Breast."

The new committee chairmen announced at this meeting were as follows: Mrs. E. E. Bauman, program; Mrs. J. A. Ralston, ways and means; Mrs. A. L. Schaffer, *Today's Health*; Mrs. D. A. Mathie, public relations; Mrs. D. A. Miller, health education; Mrs. J. W. Kohn, community project; Mrs. A. F. Compton, radio and visual education; Mrs. J. R. Willoughby, legislation; Mrs. C. A. Anderson, archives; Mrs. S. J. Shapiro, sunshine; Mrs. J. C. LaVoo, telephone; Mrs. T. P. Berry and Mrs. J. M. Gleshill, nurse entertainment; Mrs. H. J. Meister, student nurses; Mrs. A. W. Beale, scholarship and loan;

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 15, 1954. Vaginal Approach to Pelvic Surgery, one week, starting March 1, 1954.

OBSTETRICS—Intensive Course, two weeks, starting Nov. 2, 1953, March 1, 1954.

MEDICINE—Electrocardiography & Heart Disease, two weeks, starting March 15, 1954. Two-Week Intensive Course starting May 3, 1954. Gastroscopy, two weeks, starting March 8, 1954.

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It was announced that a bed with side boards has been donated to the Trumbull County Home.

The student nurses' entertainment committee of the Auxiliary held two picnics during September for the student nurses. Outdoor games were played during the day, and after supper, dancing and bingo were enjoyed. Mrs. J. M. Gleshill was hostess for the first picnic, and the second was held at the home of Mrs. T. P. Berry.

TUSCARAWAS

The Woman's Auxiliary to the Tuscarawas County Medical Society met September 10 at the home of Mrs. M. W. Everhard, new Philadelphia, with Mrs. R. A. Wilson of Dennison presiding.

Plans were made for the members to act as hostesses at the county-wide Health Day sponsored by the County Medical Society, on which day, parents and teachers were scheduled to meet with the physicians for panel discussions and health topics of interest to all.

Mrs. John Bell of Uhrichsville gave a very interesting and informative talk on the subject, "The Sesquicentennial Year."

WASHINGTON

Plans for the annual benefit bridge were made at a committee meeting at the home of Mrs. Donald S. Williams. Proceeds will be given to Marietta Memorial Hospital. Others assisting Mrs. Williams were Mrs. George Hille, Mrs. Deane Northrup, and Mrs. George Huston.

Eighth District Schedules Program In Cambridge, November 12

Speakers for the fall postgraduate program of the Eighth Councilor District Medical Society, to be held in Cambridge, November 12, will be Dr. Scott R. Inkley, Instructor in Medicine, and Dr. Harold S. Ginsberg, associate professor of preventive medicine, both of the Western Reserve University College of Medicine.

Dr. Inkley will speak on the subject "Indication for Cardiac Surgery in Acquired Valvular Heart Disease," and Dr. Ginsberg on "Can Poliomyelitis be Prevented?"

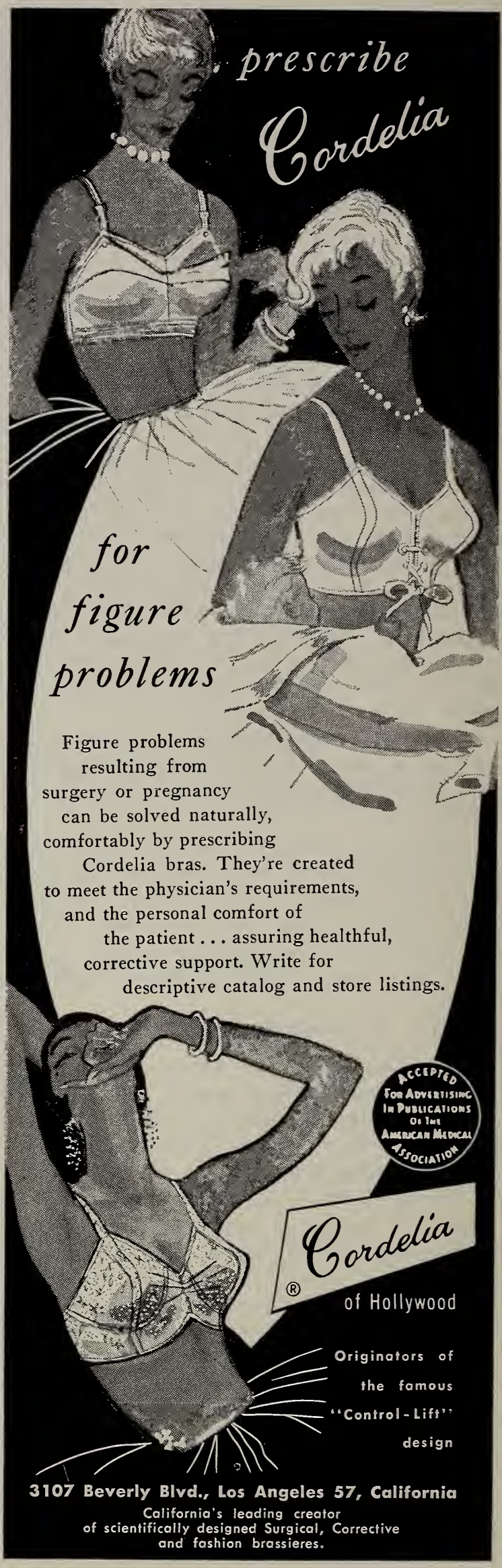
The meeting will begin at 12:30 p. m. with an open house at the Guernsey Memorial Hospital in Cambridge. Refreshments will be served.

At 2:30 p. m. the scientific session will begin at the Elks Club, corner of Wheeling and Eleventh Streets, Cambridge.

A cocktail hour is scheduled for 5 p. m. and dinner at 6 p. m., both at the Elks Club. The price of the dinner will be three dollars.

Reservations may be placed with Dr. Earl E. Conaway, in care of the Guernsey Memorial Hospital, Cambridge.

A separate and concurrent program has been planned for the members of the Woman's Auxiliary in the Eighth District.



Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states. Intended city of residence stated in application and medical school of graduation are given.

June 16—Edward A. Ernst, Lodi, Temple University; Harold W. Ford, Cleveland, Howard University; John H. H. Gibbon, Royal College of Physicians and Surgeons, London, England; Frank K. Inui, Youngstown, Johns Hopkins; Arthur J. Johnson, Logan, University of Michigan; Raymond A. Klinger, Baltic, Hahnemann Medical College (also licensed by examination).

August 25—Elmer W. Adams, Indiana University; Jack L. Alter, Dayton, Northwestern University; Philip Andrews, Dayton, University of Texas; John L. Bacon, Findlay, University of Maryland; Robert E. Baker, Cincinnati, Wayne University;

Robie T. Childers, Jr., Massillon, Emory University; Edward Davison, Queen's University of Belfast; Paul D. DeWitt, Cleveland, University of Georgia; Charles R. Dubiel, Columbus, Northwestern University; John W. Durkin, Jr., Cincinnati, University of Vermont;

Percy W. Edgecombe, Cleveland, Dalhousie University; Burtis R. Evans, Cleveland, Temple University; John A. Fischer, Dayton, Albany, University; Charles D. Ford, Toledo, New York Medical College; Donald R. Fox, Cincinnati, Temple University;

Joseph M. Gist, Zanesville, Washington University; Jay C. Gore, Cleveland, University of Maryland; Louis A. Gottschalk, Cincinnati, Washington University; Emanuel R. N. Grigg, University of Cluj, Roumania;

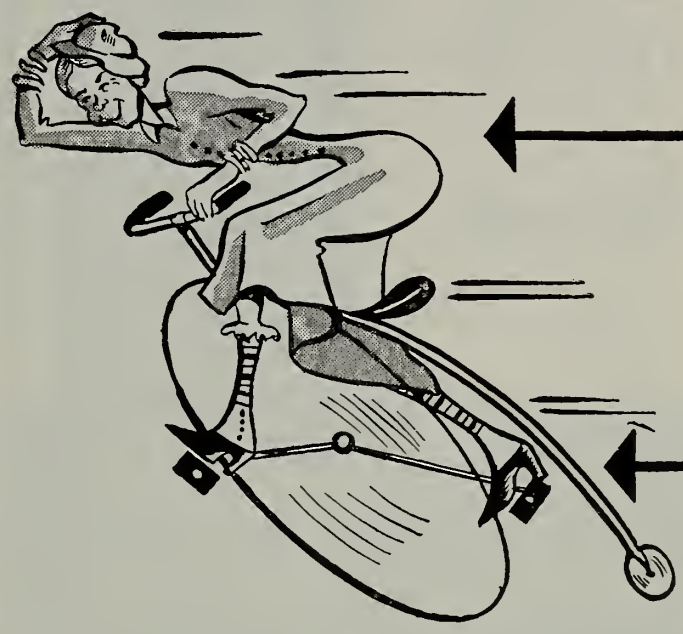
Austin H. Hammond, Cleveland, University of Rochester; Russell C. Herman, College of Medical Evangelists; Erwin P. Hoffman, Toledo, St. Louis University; Gerard J. Horn, Fremont, St. Louis University; Robert G. Hughes, Columbus, St. Louis University; Thomas W. Hunter, Sidney, Hahnemann Medical College; George J. Iten, Orrville, University of Maryland;

Lee Jackson, Cleveland, University of Rochester; Ralph W. Jacobs, Hudson, Harvard; Drue King, Jr., Cleveland, Tufts College Medical School; Morton M. Krieger, Cleveland, University of Maryland;

Clarence R. Laing, Cleveland, Howard University; Harold J. Laughlin, Morrow, St. Louis University; Gail Ann Locken, Columbus, University of Michigan; Sheldon Loeb, Cleveland, Chicago Medical School;

Stephen R. Markey, Fostoria, Loyola University; Marjorie McDonald, Cleveland, University of Rochester; Patricia S. McKenna, Cincinnati, Northwestern University; Robert L. McLaurin, Cincinnati, Harvard; Rex O. McMorris, Co-

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Sidney L. Schuchter, Cleveland, Chicago Medical School; S. William Simon, Dayton, Rush Medical College; Martin L. Smith, Cleveland, Meharry Medical College; Martin F. Sturman, Cleveland, State University of New York; Yuan-Mei Sun, Dayton, University of Michigan; Henry H. Swope, Jr., Worthington, New York Medical College;

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Regional Meeting on Rheumatism To Be Held in Akron

The complete program has been announced for the Ohio and Western Pennsylvania Regional Meeting of the American Rheumatism Association to be held in the Mayflower Hotel, Akron, on Wednesday, November 11.

Subjects and speakers are as follows:

"Prevention and Treatment of Rheumatic Fever," Dr. Currier McEwen, New York Medical School.

"Differential Diagnosis of Rheumatoid Arthritis," Dr. Charles Ragan, Columbia University.

"Rational Management of the Patient with Chronic Arthritis," Dr. Richard H. Freyberg, University of New York Medical School.

"The Management of Musculo-Skeletal Lesions of Rheumatoid Arthritis," Dr. Robert L. Preston, New York University Postgraduate Medical School.

"The Problems of Uric Acid Metabolism and Gouty Arthritis," Dr. John H. Talbott, University of Buffalo College of Medicine.

"Practical Physical Medicine and Rehabilitation for the Patient with Rheumatoid Arthritis," Dr. Gordon M. Martin, Mayo Clinic and University of Minnesota Medical School.

"Vascular Lesions in Rheumatoid Arthritis," Dr. Joseph J. Bunim, National Institutes of Arthritis and Metabolic Diseases.

Dr. Roger Q. Davis, 1405 Goodyear Blvd., Akron 5, is acting regional chairman for the meeting.

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Columbus and Cleveland Societies Sponsor Public Health Forums

The Columbus Academy of Medicine and the Academy of Medicine of Cleveland are both sponsoring series of health education forums for the public in cooperation with local newspapers.

The forum programs are similar to those sponsored in Dayton by the Montgomery County Medical Society last Spring in cooperation with the *Dayton Daily News*. The Dayton meetings were enthusiastically received and it was estimated that more than 5,000 persons heard the lectures.

COLUMBUS PROGRAMS

As this issue of *The Journal* went to press, the Columbus Academy in cooperation with the *Columbus Dispatch* was preparing for the first of its series of Forums to be held on October 22 in the Central High School Auditorium at 8 p. m.

Four successive Thursday forums were scheduled as follows: October 22—"You and Your Child"; October 29—"You and Your Nerves"; November 5—"You and Your Heart"; and November 12—"Live Long and Like It."

Dr. Harrison S. Evans, public relations chairman, appointed Dr. Thomas E. Rardin, chairman of the forum group. He is assisted by Drs. Grant O. Graves, Thomas E. Shaffer and Richard W. Zollinger. They are assisted by Stanley R. Mauck, executive secretary; Mel Tharp, manager of Promotion Department of *The Dispatch*, and the public relations firm of Byer & Bowman.

Each forum presents a speaker on the general subject who opens and closes the discussion. A moderator and four medical panelists answer questions submitted in advance through a public newspaper poll.

CLEVELAND SERIES

The Cleveland Academy and the *Cleveland Press* are co-sponsoring a series of health education meetings beginning October 27 in the Music Hall of the Public Auditorium at 8 p. m.

Subjects on the program are the following: October 27—respiratory diseases; November 11—arthritis; November 18—heart disease; November 25—cancer.

The overall plan of the Cleveland meetings are the same as those in Columbus. A 15-minute opening talk will be followed by a panel discussion during which written questions submitted before the meetings will be answered.

The Cleveland meetings are held as an activity of the Academy's Health Education Committee under Dr. William P. Garver. Medical aspects are arranged through a subcommittee headed by Dr. Edward A. Marshall.

Cleveland—Dr. Webb P. Chamberlain, Jr., is the new president of the Western Reserve University Medical Alumni Association.

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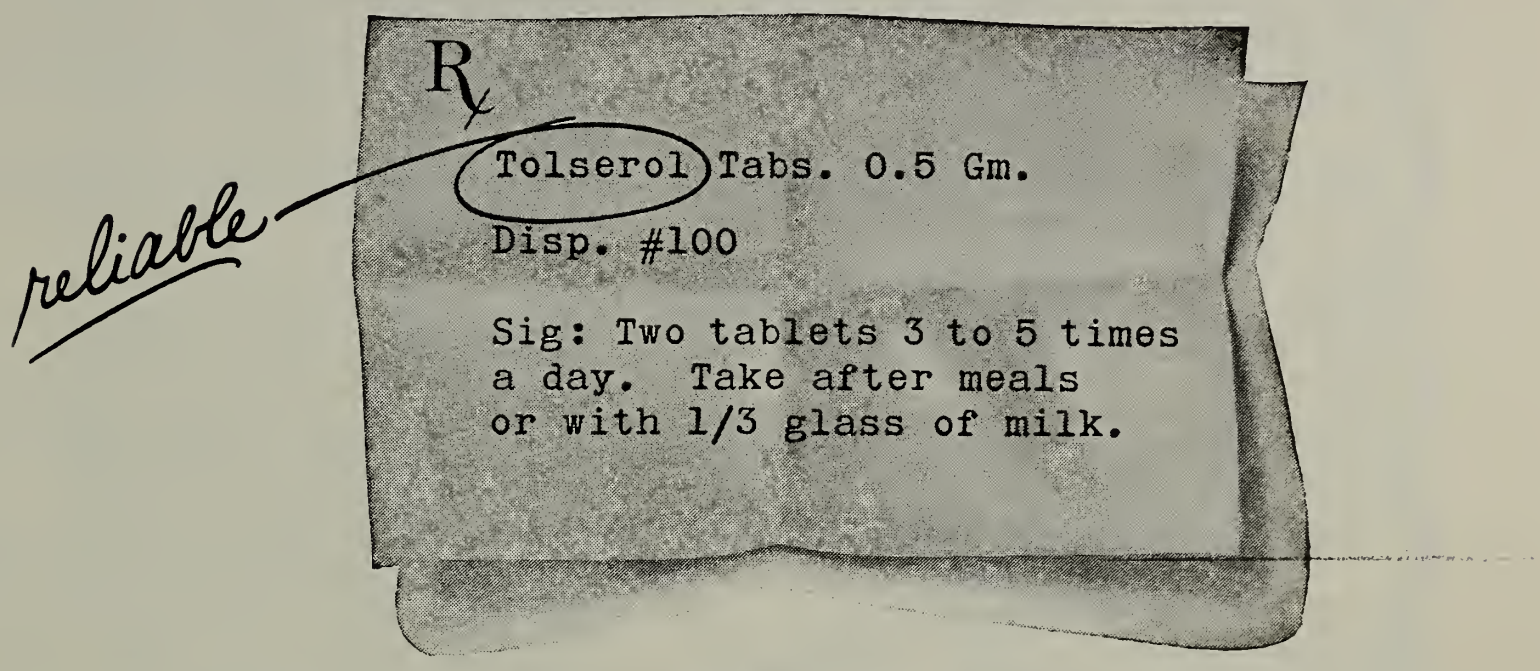
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MADISON—J. William Hurt, President, West Jefferson; Sol Maggied, Secretary, West Jefferson. 1st Wednesday.

MORROW—Stanley L. Brody, President, Cardington; David James Hickson, Secretary, Mt. Gilead. 4th Tuesday.

PICKAWAY—Ned B. Griner, President, Circleville; Ray Carroll, Secretary, Circleville. 1st Friday, monthly.

ROSS—Francis W. Nusbaum, President, Chillicothe; Charles N. Hoyt, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—B. E. Ingmire, President, Plain City; Walter R. Burt, Secretary, Milford Center. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Charles F. Gibbons, President, Ashland; Howard R. Wetzel, Secretary, Ashland. 1st Friday, monthly.

ERIE—Joseph P. Ohlmacher, President, Huron; H. F. Kesinger, Secretary, Sandusky. 4th Thursday, monthly.

HOLMES—Luther High, President, Millersburg; Owen Patterson, Secretary, Millersburg. 1st Wednesday, monthly.

HURON—H. A. Erlenbach, President, New London; Frederick B. Western, Secretary, New London. 2nd Wednesday March, June, September, December.

LORAIN—George R. Wiseman, President, Amherst; L. H. Trufant, Secretary, Oberlin. 2nd Tuesday, monthly.

MEDINA—Herbert F. Cowgill, President, Wadsworth; Otis G. Austin, Secretary, Medina. 3rd Thursday, monthly.

RICHLAND—Donald W. Dewald, President, Mansfield; Harlin G. Knierim, Secretary, Mansfield. 3rd Thursday, monthly, except June, July and August.

WAYNE—Robert A. Anderson, President, Wooster; R. C. Paul, Secretary, Wooster. 2nd Wednesday, monthly.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Atlas of The Mouth, by Maury Massler, D. D. S., and Isaac Schour, D. D. S., ($2.50. Published and distributed by *The American Dental Association, 222 East Superior Street, Chicago 11, Ill.).* To meet the demand for such an atlas the plates have been selected principally to illustrate those anatomic structures and physiologic conditions as well as certain pathologic conditions of the oral cavity that are of common interest to both the dentist and the physician.

Physiological Approach to The Lower Animals, by J. A. Ramsay, ($2.75. *Cambridge University Press, New York 22, N. Y.).* Dr. Ramsay, lecturer of zoology at Queens' College, holds that the student is likely to be misled if he approaches the physiology from the viewpoint of the higher animals. He insists that it is better to start afresh by defining the general problems that face all animals and then to learn how these problems are solved at the various levels of structure and organization. These problems are grouped into chapters on nutrition, circulation, respiration, excretion, muscle and nerve, sense organs, coordination and behavior.

Current Therapy 1953, edited by Howard F. Conn, M. D., ($11.00. *W. B. Saunders Co., Philadelphia 5, Pa.).* This annual volume is one your reviewer always looks forward to reading. Each year some two hundred new contributors selected on merit by a distinguished group of consultants to the Editor, give the details of how they would manage and treat patients with the disease for which they have been assigned and for which they have gained a national reputation. There is no better way to improve our use of the good therapeutic books at our disposal than by consulting these volumes.

Your Health, Sir!, by Miriam Lincoln, M. D., ($2.75. *Harper & Brothers, New York 16, N. Y.),* has been written specifically about the health problems of men. It tries to give the modern American rushing from one thing to another, insecure in his business and his home, a wealth of information for the promotion of health and a more effective life in spite of these handicaps.

Versalius on The Human Brain, edited and translated by Charles Singer, ($5.75. Published for The Wellcome Historical Medical Museum, by Geoffrey Cumberlege, *Oxford University Press, New York 11, N. Y.),* is the first to contain a translation into English of any substantial part of the text of the Fabrica, printed at Basel in 1543. This was the first great work of science in the modern manner; the first to adopt the exact graphic treatment to biological research; the first to introduce a positive basis for medical education. Dr. Singer, the eminent scholar and medical historian has selected the section on the brain as the most mature.

A Doctor's Soliloquy, by Joseph Krimsky, M. D., ($2.75. *Philosphical Library, Inc., New York 16, N. Y.).* Here a physician reflects and meditates on Man, Nature, and God. His years of study and practice have opened for him the door to an Intelligent Spirit, and he has found fraternity among the many prophets of religion.

The Encyclopedia of Nursing, edited by Lucile Petry, R. N., ($4.75. *W. B. Saunders Co., Philadelphia 5, Pa.),* is the first comprehensive encyclopedia planned, written and published without reference to other work, solely with the objective of its instructive and teaching value to student nurses.

Electrocardiography in Practice, by Ashton Graybiel, M. D., Paul D. White, M. D., Louise Wheeler, A. M., and Conger Williams, M. D., ($10.00. 3rd Edition. *W. B. Saunders Co., Philadelphia 5, Pa.).* After six years, we now have a completely revised, up-to-date edition of this proven text. Its main purpose is still the production of an atlas containing many tracings.

Nutrition and Diet Therapy in Relation to Nursing, by Marie V. Krause, ($4.25. *W. B. Saunders Co., Philadelphia 5, Pa.),* emphasizes the objectives of the three courses in the Nursing curriculum—Nutrition, Diet Therapy and Diet Service.

Standard Values in Blood, by Errett C. Albritton, M. D., ($4.50. *W. B. Saunders Co., Philadelphia 5, Pa.),* is the first fascicle of a handbook of biological data—a compact volume containing authoritative tabular data of most pressing need to scientists working with blood.

Physical Diagnosis, by Raymond W. Brust, M. D., ($4.50. *Appleton-Century-Crofts Co., Inc., New York 1, N. Y.).* In these days of gadget medicine it is refreshing to encounter a teacher who invites us to use our senses in the diagnosis of bodily states and who gives us a handy book which sticks to the text.

The Psychiatrist and The Law, by Winfred Overholser, M. D., ($3.50. *Harcourt, Brace & Company, 383 Madison Avenue, New York 17, N. Y.),* is by the first recipient of the Isaac Ray Award (given annually by the American Psychiatric Association), Dr. Winfred Overholser, Superintendent of St. Elizabeth's Hospital, Washington, D. C. He summarizes briefly and clearly the history and present position of psychiatry, a plea for a closer rapprochement between law

and medicine, the different state laws governing the mentally ill under the title "The Mental Patient and The Hospital" and the final section is devoted to the role of the psychiatrist in the courtroom.

Synopsis of Obstetrics, by Jennings C. Litzenberg, M. D., revised by Charles E. McLennan, M. D., ($5.50. Fourth Edition. *C. V. Mosby Company, St. Louis 3, Mo.).* The new author has deleted and completely rewritten most of major sections particularly those dealing with the early days of the ovum and endocrinology.

Teeth, Health and Appearance, ($3.50. Third Edition. Published by *American Dental Association, 222 East Superior Street, Chicago, Ill.).* A popular illustrated manual explaining the subject in very clear fashion to the layman.

Rehabilitation of The Physically Handicapped, by Dr. Henry H. Kessler, ($4.00. Revised Edition. *Columbia University Press, New York 27, N. Y.).* This is rapidly becoming an accepted part of our way of life in peace times as well as in war. Like all phases of medical progress, advances in this field have kept pace with advances in science and can of course go no faster. The author is an international authority.

Elementary Statistics with Applications in Medicine, by Frederick Emory Croxton, Ph. D., ($10.00. *Prentice-Hall, Inc., New York 11, N. Y.).* Most of us physicians have background of previous study of statistics and usually only a modest knowledge of mathematics. Yet most of us like to list our number of cases studied, and the percentage of incidence. Here is a book which will be of great help to all of us in such uses of our experiences.

Your Arthritis—What You Can Do About It, by Alfred E. Phelps, M. D., ($3.00. Revised Edition. *William Morrow and Company, Inc., New York 16, N. Y.).* Being a worthwhile patient's manual (first published in 1943), it is designed to help the patient in his arthritis and is in no sense a substitute for the doctor's care.

Cornell Conferences on Therapy: Volume VI, under the direction of the Editorial Board, ($4.00. *The Macmillan Company, New York 11, N. Y.).* This series continues to emphasize that Pharmacology and Therapeutics must be integrated if sound teaching is to be performed for they are but two faces of the same coin. The current volume presents 15 conferences and a wide variety of topics.

A Manual of First Aid for Mental Health, In Childhood and Adolescence, by Sidney L. Green, and Alan B. Rothenberg, ($4.00. *Julian Press, New York 18, N. Y.),* is an attempt to meet the great need as shown by the fact that almost two million men were rejected by Selective Service for mental and emotional disorders and an additional 700,000 service men were discharged for the same reasons. This text is designed to meet the need for a book on mental health First Aid corresponding to the American Red Cross's First Aid Textbook.

Liver Injury, edited by F. W. Hoffbauer, M. D., ($4.00. *The Josiah Macy, Jr., Foundation, 16 W. 46th St., New York 36, N. Y.),* is the Transactions of the Eleventh Conference on the subject sponsored by this Foundation. Infective Hepatitis, Enzyme Activity of the Liver, Morphology of the Liver, Mechanicism of Bile Secretion, and Hepatic Histochemistry are presented and discussed by some 16 authorities.

Hold Your Weight Losses, by Guielma Alsop, M. D., ($2.95. *The Abelard Press, 381 Fourth Avenue, New York 16, N. Y.),* dedicated to the principle that body weight depends on habits, temperament, family and friends as well as what you eat. It is easy enough to get the patient to take off from 10 to 25 pounds, but to hold this loss is another matter. This book in the hands of your patient ought to help do just that.

Urological Nursing, by David M. Davis, M. D., and George H. Strong, M. D., ($3.25. Fifth Edition. *W. B. Saunders Company, 218 W. Washington Square, Philadelphia 5, Pa.).* A standard text now revised and brought up to date. A book whose authors have seen the female nurse give up her prejudices against urological cases and take advantage of the wonderful opportunities for service in this field.

Ulcers and Stomach Troubles: Their Causes and Relief, by Sidney Alexander Portis, M. D., ($2.00. *Hanover House, Garden City, N. J.).* This compact volume carries new hope to those who suffer from "stomach trouble." The author discusses his subject with the reader. He offers sound advice based upon years of experience in a most acceptable form.

Introduction to Medical Science, by Gulli Lindh Muller, M. D., and Dorothy E. Dawes, R. N., ($4.75. Third Edition. *W. B. Saunders Company, Philadelphia 5, Pa.),* follows the original purpose to provide a textbook for the young student nurse to serve as an overview of medical science prior to clinical instruction on the wards. It acquaints the student with the cause of disease, with methods of diagnosis, and with the bases for treatment, preventive measures and methods of control.

Garrod, Botten & Thursfield's Diseases of Children, edited by Alan Moncreif and Philip Evans, (in two volumes, 5th Edition. $21.00. *Edward Arnold & Co., London; for U. S. A., Williams & Wilkins Co., Baltimore 2, Md.),* a complete, clearly but succintly written work of nearly 2,000 pages of pediatric reference. It is well written and satisfactorily complete and up to date.



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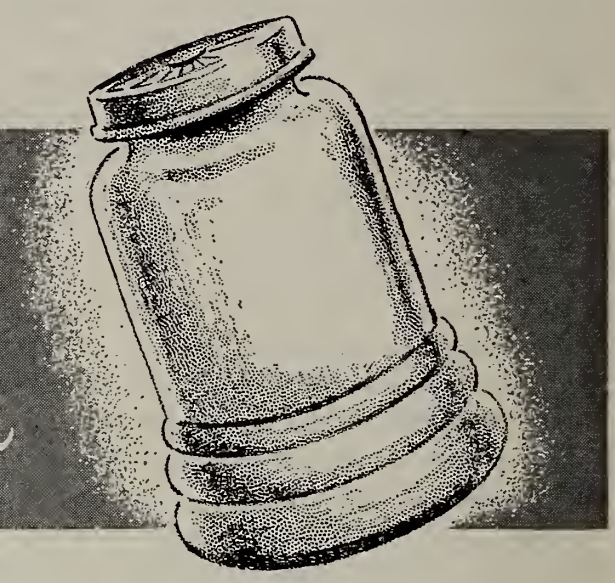
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JONATHAN FORMAN, M. D., *Editor*

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Treatment of Chest Injuries

DAVID K. HEYDINGER, M. D., and KARL P. KLASSEN, M. D.

THE definitive treatment of chest injuries, seen with increasing frequency in civilian practice, has not kept pace with the rapid progress made in thoracic surgery. It is essential that all those who care for accident cases have a thorough working knowledge of the disturbed physiology of chest injuries.

Injury to the thoracic cage is particularly serious because of the frequent concomitant injury to the underlying lungs, heart, and great vessels. As in injury to any part of the body, blood loss is hazardous; however, in chest injuries it is particularly so because the resulting tissue anoxia is markedly hastened by the disturbed respiratory function. Therefore, in treating these patients, general surgical principles must be applied in order to restore both the circulation and respiration to normal. The mechanics of respiration are well known and any injury to a single or all components of this ventilatory mechanism will result in various degrees of respiratory dysfunction.

SIMPLE RIB FRACTURES

Uncomplicated or simple rib fracture is a common and fairly painful experience. Although such injuries are frequently regarded with little concern, serious complications may occur. The jagged end of a fractured rib may tear the lung causing a hemothorax, a hemopneumothorax, or a tension pneumothorax. Hence, all such patients should have the benefit of x-ray examination.

The main symptom in a simple, uncomplicated rib fracture is pain. The usual method of treatment by tight strapping of the chest is not only uncomfortable but in most cases is of little value. The best treatment is intercostal nerve block proximal to the fracture of the rib involved, plus the rib above and below the injury. Such nerve block is a simple procedure and consists of injection of approximately 5 cc. of 1 or 2 per cent novocain® just beneath the rib posteriorly.

COMPLICATED RIB FRACTURES

Severe compressive trauma to the thorax, as seen in automobile accidents or falls, and which constitute by far the greatest number of thoracic injuries in civilian practice, usually results in multiple rib and sternal fractures. Such injuries may lead to immediate death; however, when not immediately fatal, varying degrees of respiratory and circulatory malfunction ensues.

Multiple fractures of the ribs and sternum produce a flail chest. Respiration is ineffectual because the downward inspiratory movement of the diaphragm causes sucking in of the flail chest (paradoxical respiration). The pleura is penetrated by the jagged ends of the fractured ribs with laceration of pulmonary tissue and resulting

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From the Thoracic Surgery Service, White Cross Hospital and University Hospitals, Columbus, Ohio.
Submitted May 13, 1953.

hemothorax and pneumothorax. Hemorrhage into the pleural space may be of sufficient degree to cause shock; however, it is not the hemorrhage alone but rather the pressure effect of blood and air causing pulmonary compression and mediastinal shift that are responsible for the progressive respiratory and circulatory embarrassment..

When such a severely injured patient reaches the emergency room a definite plan of management should be in effect for prompt diagnosis and treatment. Inspection of the patient on arrival will make general supportive measures obvious. Shock is immediately treated with plasma and the need for whole blood is determined. Severe pain and apprehension may require narcotics, but these should be used sparingly in respiratory and circulatory depression. In the presence of a clear airway or following tracheal aspiration, oxygen administration is essential.

Following institution of these measures a careful physical examination can be performed to determine the extent of the thoracic and other injuries. The value of x-ray examination with the patient in an upright position cannot be overestimated. This admission film, to a great extent, determines the type of therapy to be applied in a given case. The amount of blood in the pleural space should not be minimized since up to 500 cc. may collect in the posterior diaphragmatic gutter before being apparent on the x-ray.

The purpose of all phases of therapy in chest injuries is directed toward re-establishment of normal respiratory function by obtaining adequate respiratory movement of the thorax and complete aeration and expansion of all lobes of the involved lung.

Single or multiple rib fractures with a hemothorax in the absence of intrapleural air indicates, as a rule, hemorrhage from a torn intercostal vessel rather than pulmonary bleeding and usually such hemorrhage can be controlled by conservative measures. As in simple rib fractures the pain is controlled by novocain® injections. Expansion of the lung with sealing off of the bleeding points is accomplished by removal of the blood through adequate closed intercostal drainage.

Closed drainage is preferred over multiple thoracentesis because the latter is painful and disturbing to the patient and will not adequately remove all of the blood. Removal of the blood prevents its organization into a fibrous membrane with permanent compression of the lung or empyema formation. Adequate drainage is obtained by using a firm No. 30 French de Pezzer catheter which is inserted under local anesthesia in the eighth or ninth interspace in the mid-axillary line (Fig. 1). A large de Pezzer catheter is used to prevent obstruction by clots and insure continuous drainage. Also, the large head of the catheter prevents its accidental extrusion from the thorax.

The catheter is placed in the mid-axillary line to allow free movement of the patient without discomfort. The progressive expansion of the lung will force the blood through the catheter even though it is not in the most dependent position. The catheter is easily inserted after a small skin incision by stretching it over the tip of a hemostat. It is then connected to an underwater drain. This drainage bottle is placed on the floor by the patient's bed and the fluctuating column of water in the tube will indicate the patency of the tube and negative pressure in the pleural space. As the lung re-expands with drainage of the blood, the amplitude of the fluctuations in the tube will decrease and cessation of hemorrhage will be indicated by change of the bright red drainage to a serosanguinous then serous fluid.

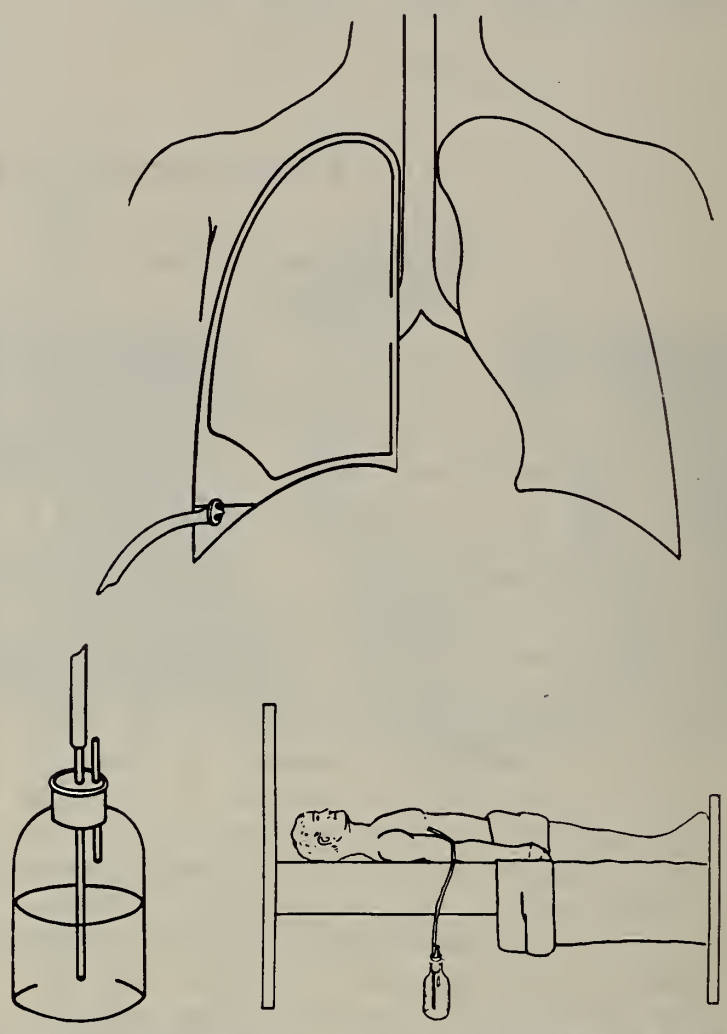


Fig. 1. Type of de Pezzer catheter underwater drainage used for treatment of hemothorax and hemopneumothorax.

The amount of blood lost can easily be determined and replaced by adequate transfusions. Such changes usually occur within 24 to 48 hours, at which time the tube can be removed if x-ray shows complete expansion of the lung. Should bright red drainage continue and re-expansion of the lung not occur after 24 to 48 hours, the hemorrhage is not controlled by this method and thoracotomy should be performed. Antibiotics such as penicillin and streptomycin may be placed in the pleural cavity daily through the tube.

As a rule, with multiple rib fractures, perforation of the parietal pleura is associated with

various degrees of severity of pulmonary laceration. In addition to intercostal bleeding, hemorrhage will occur from the pulmonary vessels and air will enter the pleural space through the torn alveolar spaces and bronchi. Therefore, to the effect of intrapleural hemorrhage is added the factor of gradually increasing accumulation of intrapleural air.

Coughing forces more air under pressure through the torn bronchi leading to a high intrapleural pressure. This causes progressive collapse of the lung and mediastinal shift leading, unless such tension pneumothorax is corrected, to serious respiratory embarrassment. The insertion of a size 18 needle into the pleural cavity will relieve the tension until underwater drainage is established (Fig. 2).

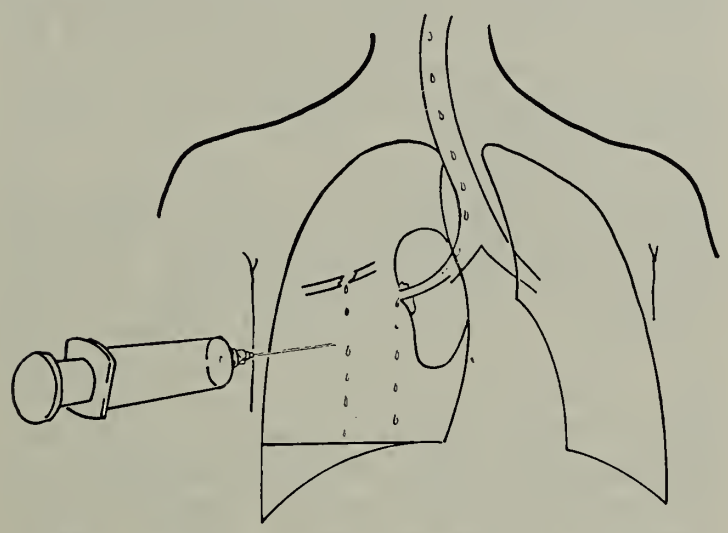


Fig. 2. Insertion of a Size 18 needle into the pleural cavity is used to relieve the pressure in tension pneumothorax until underwater drainage is established.

Air may be forced into the subcutaneous tissues through the torn parietal pleura with resultant progressive subcutaneous emphysema which may involve the entire body. Such subcutaneous emphysema, even though severe, will disappear with relief of the high intrapleural pressure and in itself is not dangerous.

The treatment of hemopneumothorax can readily be accomplished by simple, adequate, intercostal closed drainage. Such drainage will relieve the increased intrapleural pressure, will remove the blood, and expand the lung unless damage to the lung is very extensive and results in marked leakage of air or excessive hemorrhage, in which case thoracotomy should be performed at once. If closed drainage does not establish the negative intrathoracic pressure in a relatively short time, such lack of negative pressure being indicated by bubbles of air continuously escaping through the underwater tube with cough, negative pressure may be established using a controlled suction with a Stedman pump (Fig. 3).

The patients who do not make satisfactory progress with the outlined therapy will require thoracotomy and surgical repair of the injuries. Surgical intervention has become safe and will frequently greatly shorten morbidity and lessen mortality. The pre-requisites for thoracotomy are endotracheal anesthesia and availability of blood.

The incision of choice is the postero-lateral intercostal incision and posterior section of the adjacent ribs. All blood is removed from the pleural cavity and expansion of the lung is created by the anesthetist. This procedure demonstrates the areas of injury with associated bleeding and leaking of air. If a lobe is badly lacerated, occasionally a lobectomy must be done. However, many lacerations can be simply approximated with fine catgut sutures; many others, after suture-ligature of the large bleeding points, will approximate fairly well without loss of air when expansion is created by the anesthetist.

When airtight closure of the lung has been obtained, and following instillation of antibiotics, the fractured and sectioned ribs are aligned by using intramedullary bone pegs. Postoperative discomfort is slight when the involved ribs are pegged. An intrapleural de Pezzer catheter underwater drain is used for 48 hours, at which time x-ray usually shows complete expansion of the lung.

STERNUM FRACTURES

Fairly severe blunt trauma to the anterior chest wall is often well tolerated because of the spring-like character of the ribs and pliability of the costal cartilages. Severe cardiac contusion

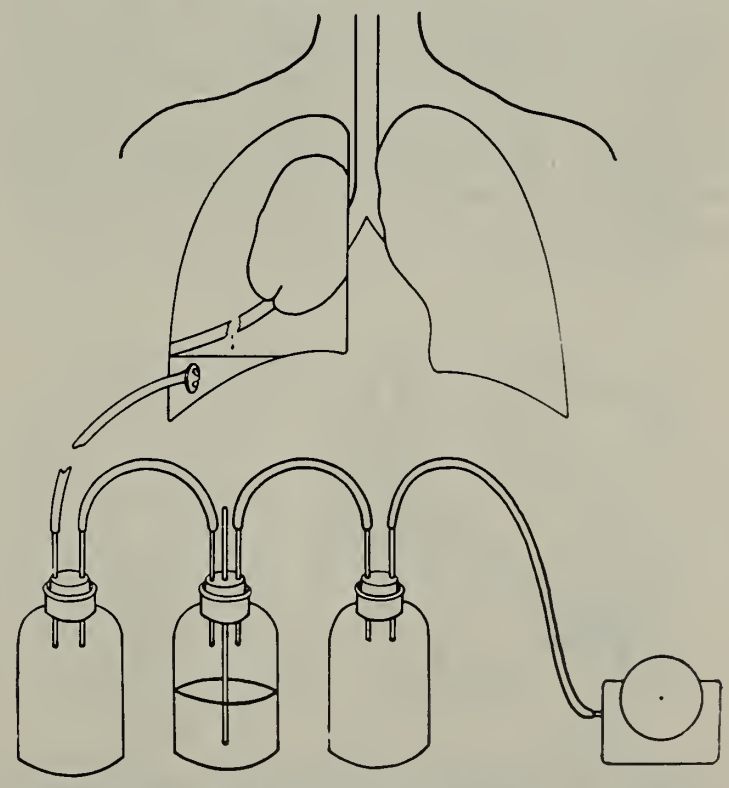


Fig. 3. When closed drainage does not establish negative intrathoracic pressure adequately, negative pressure may be established using a controlled suction with a Stedman pump.

may occur without fractures of the ribs or sternum. Fractures of the sternum with or without costal cartilage separations and rib fractures may result in a flail anterior chest wall. Only when there is such paradoxical breathing should an attempt be made to stabilize the anterior chest wall. Under local anesthesia towel clips are hooked

into the sternum and fastened to overhead traction. Open reduction is occasionally necessary. All such patients should have electrocardiographic tracings which, in this type injury, may show anything from non-specific changes in the S-T segment to evidence of acute myocardial infarction. All possible cardiac contusions should be treated as acute myocardial infarctions.

DIAPHRAGMATIC RUPTURE

Rupture of the diaphragm occurs when a severe compressive force is applied to the lower thorax. Rib fractures with this type injury are usually absent because of the greater flexibility of the ribs in this area not being directly attached to the sternum. Pain of the lower thorax with referred shoulder pain is usually present. Herniation of abdominal contents into the thorax may cause severe dyspnea and strangulation of the intestine may occur. All cases with diaphragmatic rupture should have the benefit of thoraco-abdominal exploration. The ruptured diaphragm is repaired with interrupted sutures of black silk after phrenic crush. Postoperative intercostal drainage is used.

PENETRATING THORACIC INJURIES

The majority of penetrating injuries of the thorax in civilian practice are the result of intentional or accidental wounds from bullets, knives and similar weapons. In such injuries it is not the character of the penetrating object that determines the extent of intrathoracic injuries, but rather its intrathoracic course and relation to vital structures. It is impossible to determine the course of the object by the history of the accident or the appearance of the external opening (Fig. 4).

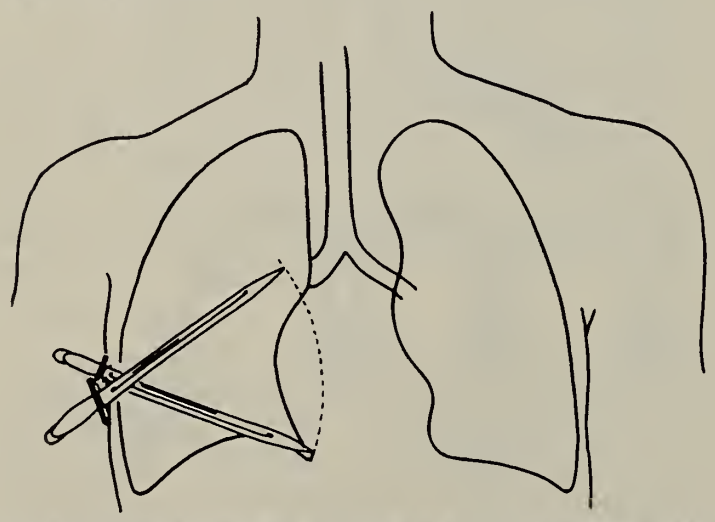


Fig. 4. It is impossible to determine the course of a penetrating wound by the history of the accident or the appearance of the external opening.

Small penetrating injuries with involvement of the lung or mediastinum not injuring large bronchi or vessels may not present a hemopneumothorax on x-ray examination and will require no surgical intervention. These patients will show no respiratory or circulatory changes. In such cases, foreign bodies in the pleural space, mediastinum, or within the lung itself need not be removed.

The great majority of patients with penetrating thoracic injuries present evidence of hemopneumothorax with various degrees of respiratory and circulatory difficulty. This indicates injury to important structures and calls for immediate surgical intervention. Without exploration the exact nature of the injury cannot be determined.

Before surgery, obstruction of the airway by hemorrhage into the bronchi must be relieved by frequent aspirations; open or sucking wounds are covered with a rubber dam type dressing; the patient should be placed on the side of the injury to prevent aspiration of blood into the opposite bronchial tree. An adequate thoracotomy incision is made to allow thorough examination of the involved hemothorax. The same procedure is used as previously discussed, and injury of the larger mediastinal structures such as the trachea, main-stem bronchus or esophagus can be treated by primary suture.

Penetrating injuries of the pericardium and myocardium may lead to cardiac compression from hemorrhage, easily recognizable by early progressive circulatory embarrassment with its increase of venous pressure and distended neck veins. When pericardial tap will not suffice, an anterior thoracotomy through the left pleural space will give adequate exposure of the entire heart and perforations of the myocardium can be repaired with silk sutures. Again, drainage of the pleural space is done and the pericardium is left open for a distance of several centimeters.

SUMMARY

The treatment of common chest injuries is presented. All patients must be carefully evaluated with sparing use of narcotics. The initial upright chest x-ray forms the basis of most treatment. Simple rib fractures are treated with novocain® injection of the intercostal nerves. Any associated hemopneumothorax is treated with intercostal de Pezzer catheter underwater type drainage. Penetrating wounds with hemopneumothorax require immediate thoracotomy.

Organic Headache

If migraine is suspected, simple diagnostic tests such as nitroglycerin, gr. 1/50 placed under the tongue will produce a typical hemicrania, which is then relieved by 1 cc. of dihydroergotamine injected intramuscularly.

An injection of 1 per cent procaine into the tender scar area of the scalp in post-traumatic headache or into the tender point at the top of the trapezius muscle in myalgia will relieve pain and further help to establish that specific etiology. —Hamilton Ford, M. D., and Israel Schuleman, M. D., Galveston; *Texas State J. M.*, 49:758.

Unlimited Diet in Peptic Ulcer—One Thousand Cases

E. A. MARSHALL, M. D.

THE author has previously published a paper on the subject of the use of unlimited diet in peptic ulcer.[1] The purpose of this paper is to review the theory behind the use of unrestricted diet in peptic ulcer, to stress the need for half-hourly or nearly half-hourly medication, to emphasize the need for treatment at night, point to the importance of continuing therapy elected for four to six months before stopping, to show treatment of obstruction and hemorrhage and to present statistics on 1,000 peptic ulcers which have been confirmed by x-ray examinations, with follow-up on over 250.

The subject has been alluded to in literature by several men but only in statements like, "I don't feel that diet is very important," etc. I am not aware of any work in which the importance of unlimited diet has been stressed. Indeed, except for Rossett[2] there has been little mention of the words "heal" or "cure" in relation to ulcer.

It has been my experience that disappearance of a niche as revealed by x-ray after any type of treatment means very little with regard to a healed ulcer. We have seen niches disappear in five to twenty days after therapy was started and used to be encouraged to stop treatment on such evidence. The rapid return of symptoms after such short treatment, however, assured us that though it was relatively easy to remove x-ray evidence of open ulcer, it was much more difficult and time-consuming to heal such an ulcer. Serial roentgenograms on the average patient will show everything from penetration, niche, scar, to negative; yet in most instances, the patient is in pain when roentgenological study is requested and presumably has an open ulcer.

EIGHT POINTS

Before entering into the subject of treatment I should like to discuss eight points which I have come to regard as facts:

1. An ulcer patient who cannot eat and drink everything without symptoms usually has an open ulcer.

2. An open ulcer is potentially dangerous. In this series it was the immediate cause of penetration with obstruction in 13.4 per cent, perforation in 3.2 per cent and hemorrhage in 20.9 per cent of the cases.

3. Adequate antacid-sedative therapy prevents acid-peptic activity from destroying **all** of the continuously forming fibroblasts, thus permitting healing to be in progress in the first 24 hours. This I have proved in obstruction where, within 24 hours, the stomach with marked retention was made to handle unrestricted, full diet without symptoms.

4. I consider treatment adequate if the ulcer patient first seen on a diet and in distress is able to eat unlimited diet without symptoms in 24 hours.

5. It follows that any symptoms, following the ingestion of any food or drink at any time after 24 hours, are evidence that the ulcer is open, previous treatment has been inadequate and "heavier" treatment is necessary.

6. Most patients on an adequate regimen, half-hourly or nearly half-hourly medication 16 hours per day and a minimum of two night or sleep-time feedings in addition to a bedtime feeding the other 8 hours, may discontinue all treatments at four and one-half months, continue unlimited diet and expect to be symptom-free over one year as shown later.

7. A healed ulcer not only lengthens the completely well periods but protects the patient from complications because the foods in a regular diet warn the patient the day his ulcer opens and all are instructed to re-start treatment immediately. The number of hemorrhages in the histories of these 1,000 patients were 209 before treatment. Since treatment I have had only five hemorrhages in the same group.

8. Using the concept that **the dose is enough** to permit granulation and epithelization of the ulcer, more ulcers can be healed. The recurrence or next ulcer must then be in a different place since scar tissue resists acid better than normal tissue. Ulcer personalities are fixed at seven years of age or under and a person with an ulcer personality may go years before he develops his first ulcer. Is it not possible therefore that when dealing with healed, not healing, ulcers we may have to change the dictum, "a man must

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learn to live all his life with his ulcer?" The follow-up in this paper would seem to support this opinion.

In the management of peptic ulcer while on unlimited diet it was my wish to set up an immediate schedule which would permit the patient to eat and drink everything without distress at the end of 24 hours and in addition have a margin of safety so that gain in granulation tissue was assured.

THE TABLETS*

This can be done in many ways but without combination tablets is somewhat unwieldy. For this reason, I had compounded in 1935 a tablet which would furnish neutralization, sedation, vagal and central, and combat the constipating effect of aluminum hydroxide. This tablet, No. 2, contained calcium carbonate, .5 gm., magnesium oxide, .25 gm., phenobarbital, .016 gm., and atropine, .0002 gm. This was effective but distinctly on the laxative side so another tablet which would offset these effects had to be made. Thus, in tablet No. 3, the magnesium oxide was dropped and the calcium carbonate increased to .65 gm. Therefore, tablet No. 3 is composed of calcium carbonate, .65 gm., phenobarbital, .016 gm., and atropine sulfate, .0002 gm.

Although calcium carbonate is a stronger antacid, it appeared at the time this work was started that there were certain advantages in the adsorption properties of aluminum hydroxide and this drug in the .65 gm. tablet has been used as the basis of the treatment in most cases. The day may come when calcium carbonate, a mixture of aluminum hydroxide and milk of magnesia or some other drug may supplant it.

Using the three tablets: aluminum hydroxide, tablets or capsules No. 2 and No. 3, the schedule is constructed generally on an ambulatory basis.

DOSAGE

Assuming that the patient arises at 6:30 a. m. and retires at 11 p. m. he is given two tablets (1.3 gm.) of aluminum hydroxide at 6:30, 7:30, 8:30, etc., every hour on the half-hour until 10:30 p. m. Then, at 11 p. m., 1 a. m. and 3 a. m. the aluminum hydroxide is increased to four tablets (2.6 gm.) and, unless milk allergy is present, 240 cc. of whole milk is given in addition on each of these three hours. This, I feel, is imperative.

As to the No. 2 and No. 3 tablets, the daily dose is nine tablets crushed (or capsules) unless excess tension forces the operator to add two to four more. Usually with the above 44 tablets (28.6 gm.) of aluminum hydroxide, the schedule will call for six No. 2's and three No. 3's, that is one No. 2 at 7 and 9 a. m., 1, 3, 7 and 9 p. m. with one No. 3 at 11 a. m., 5 and 11 p. m. with the first night feeding if bowel habits continue to be normal.

The foregoing schedule can be increased in two ways if the patient is not able to eat all foods (is still not healing). Milk or aluminum hydroxide may be added on the even hour (8 and 10 a. m., noon, 2, 4, 6, 8 and 10 p. m.) and aluminum hydroxide in 1.3 gm. dosage may be added to the No. 2 or No. 3 on the odd hour. This latter, with the night treatments, constitutes maximum ambulatory therapy and will usually cause the operator to use all No. 2 capsules or tablets and in many instances 15 cc. of milk of magnesia two or three times daily to cope with constipation.

Patients of the early cases were routinely given hourly therapy but I am now convinced that the average ulcer will heal sooner and the patient see the physician less often and over a shorter period of time if more nearly half-hourly therapy is used. This series contained 134 obstructions, 108 hemorrhages and 42 other difficult cases, the latter proving eventually to be failures. All of these patients were given the full half-hourly schedule. **One-third** of the 1,000 patients were overweight or did not wish to gain. These had to have day milk eliminated. Twenty-seven were victims of milk allergy and could be given no milk at all.

With regard to the importance of "over-treatment," 110 of these cases were extracted within one to two hours after a meal and there was not a single case where the pH was sufficiently high to permit granulation tissue to live. Of 48 extracted within one hour of a meal, the pH averaged 1.38. Of 62 extracted within two hours, the pH averaged 1.34.

These findings and clinical experience warn: **"The more frequent the medication, the better. Never cut down the amount started. Hold the dose and frequency started and treat a minimum of four and one-half months."**

OBSTRUCTION

The treatment of non-stenotic obstruction with its aerophagia, retention, anorexia and, frequently, nausea and vomiting was in a large measure responsible for showing that this method had merit. These patients are sick. They don't tend to get better in one day on psychotherapy and milk, for milk and cream aggravate this condition by further delaying motility. Moreover, many physicians with wide experience consider the majority of these cases surgical, almost without a trial on medicine.

We treated 134 such cases in the following manner: The stomach was emptied by tube; all food including milk was stopped for 24 hours; the patient was given one No. 2, one No. 3 and 1.3 gm. of aluminum hydroxide every half-hour for 24 hours except during the night from 11 p. m. to 7 a. m. when one No. 2, one

*Compounded by Caldwell-Bloor Company, Mansfield, Ohio.

No. 3 and four tablets (2.6 gm.) of aluminum hydroxide were given every hour. At the end of 24 hours No. 2 and No. 3 were reduced, frequently to ambulatory (nine No. 2), full, unrestricted diet was started and the aluminium hydroxide was kept at 1.3 gm. every half-hour with the usual three night treatments.

This group showed only six failures in 134 cases and these were gastrectomized. The rest took their unlimited diet and reacted much like the uncomplicated case. In a few instances a low fat diet had to be used for a week or two but all but the six failures were eventually controlled. Of especial interest was the fact that in 1,000 cases there were only eight patients with true stenosis which is, of course, a surgical condition.

HEMORRHAGE

The treatment of hemorrhage was patterned after that of obstruction with some exceptions: they were fed the first day; their sedation was not reduced to ambulatory for several days and they received hourly night aluminum hydroxide for five to ten days. The basic aluminum hydroxide schedule was 1.3 gm. every half-hour for 16 hours and 2.6 gm. every hour for 8 hours. This was not changed until they went home and then only to the ambulatory three night feedings.

The No. 2 and No. 3 tablets or capsules have been divided in hemorrhage into "heavy," "one-half heavy" and "one-fourth heavy" therapy, the latter may be continued until the patient leaves the hospital. The heavy therapy is similar to first day obstruction therapy outlined that is, one No. 2 and one No. 3 every half-hour for 24 hours except at night when for 8 hours they are given hourly, that is, 40 of each in 24 hours. This constitutes considerable phenobarbital and atropine but we have been surprised at the overwhelming number who eat, talk and are drowsy but able to wait on themselves on such a dose. The amount of atropine in "heavy" therapy is also greater than usually used, yet only five cases showed atropine psychosis and were not difficult to handle.

Although one may vary the number of No. 2 and No. 3 tablets to change bowel habits, "one-half heavy" therapy generally means a No. 2 on the hour and a No. 3 on the half-hour with alternation hourly at night. That is, 20 tablets or capsules of each in 24 hours. This dosage usually follows in the second day of hemorrhage and in some cases has been held two or three days. The record in this group on hemorrhage while on therapy is good. There were only six out of 108 who bled in the first 24 hours. All patients but one were gastrectomied. If therapy as heavy as outlined permits bleeding, surgical consultation should be obtained immediately.

For post-hemorrhagic cases "one-fourth heavy" therapy is frequently continued for the duration of the patient's stay in the hospital. It consists of one capsule or tablet every hour on the hour, night and day, i. e., 24 per day. The number of No. 2's and No. 3's varies with the bowel habits but generally sixteen No. 2 and eight No. 3 will prove adequate. The hemorrhage case after hospital discharge is treated as obstruction was (half-hourly day and three treatment night therapy).

There were 44 cases in this series classed as mild (BUN [blood urea nitrogen] normal). There were 36 classed as severe (BUN 20 to 35 mg. per 100 cc. blood). Finally, there were 28 which showed BUN values of over 35 mg. per 100 cc. of blood and these were classed as exsanguinating. There were two fatalities making a mortality rate of 1.85 per cent. Sixty-one per cent of these cases were over 45 years of age.

FOLLOW-UP

Questionnaires were sent to 600 patients and 270 responded. An average in months of **absolute freedom from distress** was determined. Of these 270 cases, 107 peptic ulcers recurred in an average of 28.9 months. One hundred and sixty-three have not yet recurred in an average of 33.6 months. There is certainly considerable evidence that the ulcers in both of these groups were healed since the average symptom-free or partial symptom-free period is 3 to 6 months. It must be pointed out that these patients took no medication after the close of their treatment schedule and ate and acted as any normal, non-allergic person.

SUMMARY

Peptic ulcers treated	1000
Unlimited diet successfully given immediately	921
Obstruction, non-stenotic	134
Failures (gastrectomized)	6
Hemorrhage	108
Failures, (gastrectomized)	5
Mortality	1.85%
Failures, ambulatory	67
Gastrectomized	11
History of hemorrhage	20.9%
Recurrence after therapy	.5%
History of perforation	3.2%
Recurrence after therapy	.1%

CONCLUSION

The procedure outlined offers nine distinct advantages:

1. Presents immediate evidence of inadequate therapy.
2. Permits a more nutritious diet.
3. Because of the rapid disappearance of the niche under heavier therapy, the differentiation of malignant from benign gastric ulcer is aided.
4. Separation of surgical from medical hemorrhagic cases is accomplished in 24 hours. A

patient who bleeds on "heavy" therapy will not likely stop on further medical treatment.

5. As pointed out, over 95 per cent of the obstructed, non-stenotic cases may be salvaged and the surgical cases are apparent immediately. Only eight cases of **true stenosis** were found in 1,000 peptic ulcers.

6. Ulcer patients add to their insecurity in many ways but there is certainly nothing about an ulcer diet which enhances their security. Ulcer patients as a group like to eat and live as normal people. It is seldom one refuses to go off his limited diet. Unlimited diet adds to his security.

7. Serious complications are markedly diminished when this method is followed. Yet these complications are found in more than one-third of the ulcer patients coming to the gastro-enterologist.

8. The follow-up shows a great increase in the period between cessation of therapy and recurrence, yet these patients are on no diet.

9. The average ulcer patient was seen by me every six weeks or about three to four times. This, with the long symptom-free period, greatly diminishes the cost of care of peptic ulcer.

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Tension Headache

Too many depressed patients with a tension headache go undiagnosed for months or years. Otherwise, a miserable existence, unnecessary expense, loss of earning power, and even suicide could be prevented. The symptoms of the mild depression, unlike the anxiety state, are not readily influenced by the environment. All complaints, especially headaches, are worse in the morning. Because of the characteristic isomnia of this illness, the patient believes that the headache awakens him. Likewise, the patient attributes to the headache his loss of zest and energy and of interest in sex, food, and the usual daily pursuits. Brooding, worry over trifles, despondency, and feelings of futility are present in variable degree.

The etiology of a depression is endogenous and treatment limited to psychotherapy is impracticable in many cases. The management of each case must be decided upon individual features. Supportive psychotherapy, attention to the physical health needs, mild daytime sedation, and the precaution to issue a limited quantity of sleep-producing drugs are recommended. The suicide potential is a constant threat. Administration of electroshock to the depressed patient with a longstanding tension headache can and does produce gratifying results.—Hamilton Ford, M. D., and Israel Schuleman, M. D., Galveston; *Texas State J. M.*, 49:757, October, 1953.

KEEPING UP WITH MEDICINE

• NEARLY 50 years ago Erlich recognized that bacteria could become drug resistant. He noted that *Trypanosoma brucei* became resistant to the dye trypan red and so survived 250 times the usual lethal dose.

* * *

• IT MAY have great significance in the future management of the allergic patient to know that most if not all of them show a low blood sugar level in the five or six hour specimens in the Glucose Tolerance Test. Several workers now claim that *hyperinsulinism* is one of the most important conditioning factors in the pulling trigger of the allergic.

* * *

• POSTURE is the key to many of the arthritic's problems.

* * *

• IN SPITE of all that has been written and said concerning the necessity of a well-balanced diet, particularly when we are past middle life, the majority of the middle-aged in our population are still abusing their bodies through faulty diets.

* * *

• EXPERIMENTS on animals and clinical observations have supplied us with ample evidence that while diet has no known bearing on cancer once it has begun its lawless destruction of a human body, diet does play an important role in the prevention of malignancy.

* * *

• GENERALLY speaking one may greatly reduce the chances of becoming afflicted with cancer by restricting the total number of calories. The diet should also be low in fats and the carbohydrates should be reduced to something like 500 calories per day. Such advice has many other advantages. But who takes it?

* * *

• THE SUSPICION grows that *vernal conjunctivitis* is related to bacterial allergy.

* * *

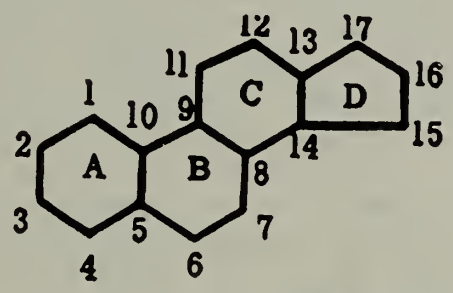
• THE ONLY safeguard we have against agranulocytosis is to instruct each patient to whom we give one of the drugs sometimes causing such a catastrophe to stop treatment at once and get in touch with a physician immediately in case of a sore throat, fever, or other illness. Penicillin is the most important step in the treatment. The drugs most likely to produce an agranulocytosis are: sulfonamide derivatives, thiourea and its derivatives, arsenicals (parental and oral), aminopyrine (pyramidon®) organic arsenicals, tridione,® mesantoin,® and physical agents such as x-ray, radium, and radioactive isotropes. Barbiturates, bismuth, organic mercurials, antipyrine, and phenacetin® have among others been reported as the probable cause of the condition.—J. F.

Sex Hormone Therapy in Gynecology*

EDUARD EICHNER, M. D.

THE endocrine glands most commonly discussed in human economy are the pituitary, thyroid, parathyroids, pancreas, adrenals and the gonads, the ovaries and testes. Their endocrine secretions are called "hormones," and the hormones of the first four glands above are protein in nature. The others are "steroids."

The steroid nucleus is specific. Basically it has four rings and seventeen carbons:



C-18, 19, 20 and 21, when present, are attached to C-10, 13, 17 and 20 respectively. For estrogenic activity, ring A is usually phenolic, and has an oxy or hydroxy radical at C-3, whereas most adrenal steroids have an oxy or hydroxy group at C-11. Similarly, androgenic compounds have somewhat typical formulas.

Sex steroids are primarily those of the ovary and testis, although the adrenal also produces steroids with sex activity. All of the hormones are influenced by the tropic hormones of the anterior pituitary, and in turn influence the production of these tropic hormones. Therefore these will be considered today in our discussion of sex hormones.

MAJOR ACTIVITIES OF STEROIDS

Animal steroids have four major activities. They may be "folliculoid" or estrogenic, "testoid" or androgenic, "luteoid" or progestational and "corticoid" or adrenal-like. In addition some have an anesthetic effect whereas others have no effect whatever. Sex steroids fall into at least one of the above classifications, and may be graded according to their activity as shown in Table I below.

PITUITARY GONADOTROPES

Since the steroids influence the pituitary gland and modify its tropic responses, a few words about these are now indicated. The pituitary gonadotropes are:

FSH or Follicle Stimulating Hormone. This produces follicle growth, but only in the presence of LH.

LH or Luteinizing Hormone. This is mediated through the hypothalamus and the nervous system by estrogen. It produces follicle growth and development of the ovum. In some animals it is necessary for the production of progesterone. This is apparently not so in human beings.

LTH or Luteo Tropic Hormone. This is also considered to be "prolactin." It maintains the secretory activity of the follicle, corpus luteum and the breast. It inhibits the release of FSH. There is no ovarian activity in the absence of LH and FSH, and there is no breast activity without estrogen and progesterone.

The placenta produces APL or Anterior Pituitary-Like hormone. This acts almost as pure LH, and thus produces ovulation in some experimental animals. This also explains its failure to do so in others.

The tropic hormones stimulate the various end-organs, and are in turn inhibited by steroids produced by these organs. Thus, estrogens suppress FSH, LH and LTH, leaving ACTH acting almost unopposed. This is the reason for some of the bizarre effects following estrogenic therapy. Androgens suppress FSH. If dosage is increased, LH is next suppressed, and finally ACTH, only on very large dosage. Corticoids suppress ACTH and TSH, the thyrotropic hormone. Thyroid suppresses TSH and FSH. It is this alternating stimulation and suppression which produces the normal cyclic menses in

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TABLE I

	Estrogenic	Androgenic	Progestational	Corticoid
1.	estradiol	testosterone	progesterone	desoxycorticosterone
2.	testosterone	progesterone	desoxycorticosterone	progesterone
3.	progesterone	desoxycorticosterone	testosterone	estradiol
4.	desoxycorticosterone	estradiol	estradiol	testosterone

*The above paper was presented from slides as part of a round table discussion on hormone therapy at the last Annual Meeting of the Ohio State Medical Association, held at Cincinnati on April 21, 1953. It has been modified and edited for publication by the author.

women, with the normal development and regression of the ovarian follicles and corpus luteum.

Similarly, it is failure of the ovary in the climacteric which results in the production by the pituitary of large amounts of FSH. The giving of exogenous estrogen decreases this activity. This is used by some in decreasing the size of cystic ovaries since many ovaries will decrease in size if FSH is not active. It is this absence relatively of FSH in the presence of high estrogens which produces the amenorrhea frequently associated with granulosa cell tumors.

ACTIVITY OF ESTROGENS

In discussing the steroids, we must first consider the estrogens. Their activity can best be summarized as follows:

1. Feminization: fat distribution, feminine hair pattern, breast size.
2. Breast: duct proliferation. Carcinogenesis is unproven in human beings.
3. Uterus and vagina: organ growth, glycogen deposition in lining membranes, and vascular growth and regression.
4. Modification in production of pituitary hormones (tropic, growth, etc.).
5. Sexual pigmentation: nipple, vulva, linea alba, etc. These changes may be produced by the adrenals.

SOURCES

Estrogens are produced in the ovary as a result of pituitary stimulation. They are probably produced in the theca rather than the granulosa, although this is a moot question at present. The adrenals also produce active estrogens. In the male, estrogens are produced by the Sertoli's cells of the testis. As a matter of fact, the stallion testis is the richest source of estrogen.

In the body, enzymes can produce estrogens from androgens, cholesterol and various carcinogens. Not over 10 per cent is excreted in the urine. It leaves the body as a conjugated estrone. Approximately 50 per cent is never accounted for. Bile is a rich source of free estrone, which is resorbed from the intestine. The estrogen produced by the human ovary is probably estradiol. All human tissues have an enzyme system for the conversion of estrone to estradiol. This action is reversible.

COMPARISONS

There is no true comparison between the various estrogens, as their rates of storage, adsorption, utilization and excretion vary within wide limits. The actual end-organ response varies with the conditioning of the animal. However, for general calculation, the following comparisons are made: 1 mg. estradiol :: 1 mg. stilbestrol :: 2.5 mg. conjugated water-soluble estrins :: 0.1 mg. ethynyl estradiol :: 0.4 mg. dienestrol.

Evaluation of the newer estrogens is not yet complete, but these will probably fall in the range of 6 to 15 mg. :: 1 mg. estradiol, which is the most active natural estrogen. However, dienestrol in comparative dosage is best for vasomotor control, but ranks poorly in vaginal response. Stilbestrol, routinely 2½ times as strong as estrone in its effect on vaginal tissues, is 100 times as potent for stimulation and release of gonadotropic and adrenotropic factors in immature mice pituitaries. Furthermore, even the value of estradiol varies with its radical, i. e. dipropionate, benzoate, etc.

PROGESTERONE

Next for discussion is progesterone, the hormone produced by the ovarian corpus luteum, specifically by the theca-lutein cells. The adrenals also produce progestational steroids, and in certain experiments, progesterone has been synthesized directly from cholesterol. It produces a progestational state in the endometrium, the endocervix and the epithelium of the vagina and bladder. It is responsible for alveolar proliferation in the breast. It has extensive experimental uses, none fully confirmed clinically. However, none of its effects will occur in the absence of estrogenic activity.

It is thought by many that the current progesterone dosage schedules are similar in degree to that of theelin in the early and middle thirties. Experimental investigation is difficult because its excretion rate (as pregnanediol) is influenced by drugs, weather, time of day and the general health of the subject. Excretion never exceeds 35 per cent recovery, and frequently will be less than 10 per cent. In large doses, progesterone is a sedative, yet it acts as a foreign substance in the tissues. Of all steroids implanted, progesterone has the highest extrusion rate. When injected in large doses it is very painful.

ANDROGENS—THEIR RESPONSES

Androgens compose the third group of sex hormones. Their responses in females are:

1. Anabolic. Androgens help control protein metabolism and growth of skeletal muscle. They cause retention of nitrogen and sodium, and stop osteoporosis. Some degree of euphoria is present.
2. Secondary sex characteristics are modified. There is enlargement and erection of the clitoris, development of sexual hair, as well as change in the larynx and voice. Many patients also respond with increased libido.
3. Sexual atrophy is produced by large doses. There is inhibition of FSH with atrophy of the endometrium and myometrium. Regression in endometrial cancer has been produced experimentally.

DOSAGE

Testosterone is the preferred androgen, but here too results vary with the radical and the solvent used. Effective dosage of many of the androgens is directly proportional to the dose necessary for androgenic effect. In general, effects are identical with the following equivalent testos-

terone doses: 1 mg. injectable :: 1-3 mg. buccal or sublingual :: 5-10 mg. oral. By the way, it is difficult to keep a buccal tablet in proper position without swallowing saliva. Try it some day. Methyl testosterone is the preferred oral androgen. Unless used in the therapy of malignancy, monthly dosage should not exceed 250 mg., and medication should be discontinued at the first signs of virilization. Ethynyl testosterone is minimally androgenic. Its most common chemical name is anhydro-hydroxy progesterone. It is primarily progestational, and is the oral progesterone offered by several pharmaceutical houses.

The foregoing concludes the brief, simplified and basic explanation of the "What, how and why" of the sex hormones. The remainder of this article gives recommendations for therapy in certain specific conditions. When feasible, oral therapy is preferred, particularly in regard to the estrogens.

Differential diagnosis will not be discussed, but I believe emphasis must be placed on the following: menopause occurs only after the cessation of menses, and does not of necessity infer climacteric, castration syndrome or hypogonadism. Similarly, normal cyclic menstruation rules out the presence of climacteric or castration syndrome. Lastly, most women who have severe vasomotor disturbances in the late forties had lesser emotional disturbances throughout their previous years.

OVARIAN HYPOFUNCTION

Ovarian hypofunction is of three types:

1. **Hypergonadotropic**: ovarian failure with a normal pituitary.
   (a) Ovarian agenesis or eunuchoidism.
   (b) Climacteric or castration syndrome, associated with menopause.
2. **Normogonadotropic**: Normal pituitary with primary failure either in the end-organ response or in the neurohumoral mechanism.
   (a) Functional bleeding.
   (b) Hypothalamic amenorrhea.
3. **Hypogonadotropic**: primary pituitary failure, and the gonads may or may not be normal.
   (a) Some pituitary tumors and dysfunctions.
   (b) Some pseudoendocrinopathies.
   (c) Some systemic diseases.

TREATMENT

Treatment in these conditions varies with the cause. Menopause and castration seldom require treatment under 25 or over 55 years of age. Sedation (phenobarbital) or stimulation (amphetamine) is frequently of greater value than steroid therapy. The euphoric effect of testosterone is occasionally useful. When estrogens are used, original dose should not exceed 0.1 mg. estradiol or equivalent daily. This may be given for 25 days each month. The dose should be reduced gradually, and can frequently be discontinued within six months. For true castration syndrome, the dose need rarely exceed 1 mg. estradiol or equivalent. Treatment as above is "cyclic."

In eunuchoidism, or prepubertal failure, progesterone should be added for the last few days of the cyclic estrin therapy. Because testosterone is required for the growth of primary sexual hair, its use is occasionally of great value. However, the type and character of the treatment depends on the patient's status.

Progesterone, 10 to 25 mg. daily, for three to five days will stop functional bleeding if estrogen is present. It will produce a "medical curettage" if bleeding results from irregular shedding of the endometrium. Progesterone failure infers the absence of active estrogen. A word of warning here is that "progesterone withdrawal bleeding" will occur within a week of the cessation of the progesterone treatment. However the patient may stop this bleeding without further treatment, and then continue normal menses. The progesterone course may be repeated once or twice if necessary.

Cyclic estrogen is helpful in the presence of cystic glandular hyperplasia of the endometrium. Testosterone may be useful in bleeding secondary to adenomyosis or fibromyomata. Cyclic APL (LH) may be given daily for three to four weeks in hypothalamic amenorrhea. This should be followed by 10 to 25 mg. progesterone daily for five days at the end of the course. Some believe that cyclic estrogen and progesterone is just as satisfactory. Using any of the oral steroids, the oral dose should be 5 times the injected dose.

OVARIAN HYPERFUNCTION

Ovarian hyperfunction has no satisfactory endocrine therapy. Androgens and progesterone may give temporary relief, but will cloud the picture. Occasionally small doses of estrogen may depress the production of FSH, and thus modify the clinical picture. Precocious puberty requires no treatment except to rule out neoplasia. However, the resultant emotional difficulties of the patient and her family may often tax the ingenuity of the gynecologist. Psychiatric assistance may be needed.

DYSMENORRHEA

Cyclic estrins starting on the fifth day of the cycle, and continuing for 20 days may produce an anovulatory cycle, and thus relieve or prevent dysmenorrhea. Androgens given immediately postmenstrual for ten days may give similar results. Although the mechanism is not fully understood, this therapy frequently relieves the pain of endometriosis and adenomyosis. When cyclic estrogens are continued for several months, the dosage must be continually increased; otherwise a "breakthrough" will occur. In this increase lies the potential danger of excessive dosage.

Tension states (premenstrual, menopausal,

climacteric or castrate) may in suitable patients be relieved by small amounts of estrogen, testosterone or progesterone. Patients with identical complaints may often be helped by totally different routines. Mild sedation, however, is the most important key to the problem. Steroid therapy cannot replace emotional understanding.

STERILITY

Treatment of sterility depends on the cause. There is no known cure for anovulatory cycles in women. Therefore, there is no constantly successful therapy. Cyclic ethynyl estradiol, 0.5 mg. daily for 12 to 20 days, starting on the fifth day of the cycle offers the best chance for a breakthrough of LH. Sometimes treatment for the two to four days preceding the expected or hoped-for ovulation will produce results, and sometimes the addition of progesterone for five days at the end of the prolonged estrogen course has apparently produced results.

Patients treated for anovulatory menstruation have conceived under all forms and types of steroid therapy, including androgens and the adrenal compounds. Thus several cases of pregnancy have been reported after the use of cortisone in sterility secondary to the various virilizing syndromes, such as the adrenogenital syndrome or the Stein-Leventhal syndrome of sclerocystic ovaries. The dose of cortisone is 25 mg. daily. This is sufficient to depress autogenous adrenal activity.

VAGINITIS

Antibiotics and the sulfas have done away with the need of estrogenic therapy in gonorrheal vaginitis of children or the aged. Estrogenic ointments, tablets or suppositories are of great help in true senile vaginitis. The local dose should not exceed the smallest amount necessary for relief, and treatment should be discontinued when the vaginal epithelium approaches normal. Systemic therapy is never necessary.

Local therapy is also of assistance in senile vulvitis. If leukoplakia, or kraurosis is present, do a biopsy before starting treatment. The patients must be observed for long periods of time as some of these lesions are premalignant. If inflammatory vulvitis is present, rule out diabetes and fungal infections. As a final word of caution, remember that more women are made worse by overtreatment, and the overindulgent use of antibiotics or "-caine" ointments than are injured by the lack of any treatment.

SUMMARY AND CONCLUSION

A brief attempt at clarifying the basic concepts in sex hormone therapy has been made. Methods of treatment of several gynecic conditions has been offered. The author hopes his "clarification" has not further muddied the already roiled waters of endocrine therapy.

Reactions to Antibiotics

According to Rutenburg and Pinkes, the orange-colored antibiotic aureomycin produces a positive test for bilirubin in the blood, indicative of damage to the liver. This test reaction rather quickly disappears on cessation of the medication. That the pigmentation is due to alteration of hepatic function rather than to the tinctorial property of the drug is indicated by the fact that the abnormal values for bilirubin in the blood may run parallel to bromsulfalein retention, as an indication of hepatic damage. Fortunately, the signs or indications of abnormal hepatic function generally disappear within two or three days after administration of the aureomycin has been discontinued.

Another series of observations on the effects of aureomycin or of terramycin® points to the complicating liabilities arising from the development of an abnormal bacterial flora within the gastrointestinal tract.

For a considerable time, reports have been appearing concerning the usefulness of certain antibiotics in the treatment of amebic dysentery. The general consensus of investigators, in regard to the mode of action of effective antibiotics in this disease, is that the drug alters the intestinal flora in such a manner that even benign amebae cannot readily survive. Perhaps the bacteria on which amebae depend are so inhibited that growth of these amebae essentially ceases. Views are now being reported to the effect that there is also a bacterial imbalance in the gastrointestinal tract which could deprive the amebae of those special bacteria which supply their nutritional necessities.

Also a concurrent, unhindered overgrowth of micrococci occurs, which in turn can cause toxemias. Thus it would appear that members of the colon group of bacteria such as Escherichia coli, together with members of the Proteus group, cease to offer effective competition to the micrococci, which then multiply in a more or less uncontrolled fashion and thereby become responsible for these toxemias. Added to the feature of micrococcal overgrowth is the likelihood that these same organisms will develop their own resistance to the antibiotics.—A. L. Tatum, M. D., Madison; *Wisconsin M. J.*, 52:417, July, 1953.

Vitamin C for the Aged

An adequate vitamin C intake may prevent many illnesses in the aged. Incidence of disabilities from heart and cerebrovascular disease may be appreciably reduced. Research has shown that vitamin C plays a vital role in cellular metabolism and in maintaining the integrity of cells.—E. T. Gale, M. D., and M. W. Thewlin, M. D., *Geriatrics*, p. 880, February, 1953.

The Day Hospital Unit——Milieu Therapy, Its Place In the Treatment of the Mentally Ill*

PHILIP C. ROND, M. D.

THE Day Hospital is as the name implies, a hospital unit which operates only during the day time hours, ordinarily from 8:00 a. m. to 4:00 p. m., as a functional part of a psychiatric hospital. Our unit in Columbus is part of the Columbus Receiving Hospital.

Historically, this approach to mental illness seems to have been first used on this Continent in Canada by Dr. D. Ewen Cameron[1] at the Allen Memorial Institute in the early 1940's. Since this time, similar programs have been introduced at Menningers,[2] and Yale[3] and now at Ohio State University Medical Center. The program at the Columbus Receiving Hospital in the Medical Center was opened August 25, 1952.

Dynamically, our Day Hospital is set up with a strict observance of the basic assumption that individuals develop symptoms within a social setting. Dr. Cameron states that the Day Unit gives expression to "the fact that patients do not need to stay in bed; that they do not have to remain in the hospital until they are well, and indeed, often do not get well if we try to make them stay; and that it is not only the patient but also his family unit and his general social setting which require to be treated." In Columbus our goal has been to create a social milieu setting in which the individual patient's interpersonal relationships are observed and utilized in a therapeutic manner.

INTENSIVE PROGRAM

Our program is rather intensive and designed to prevent regressive trends in the patient's personality from becoming more acute. Needless to say, we have not always realized this goal. Nearly every relevant verbalization and action of the patient is observed and recorded by the various members of the staff, and these are utilized in staff meetings to evolve the proper therapeutic aims and attitudes to be maintained with the patient.

The program is democratic, the patient community develops its own leaders, and the group interaction is at all times utilized as therapeutically as possible. Because the patients return to their own homes each evening, they have the opportunity to apply immediately any new patterns of behavior which they develop as a result of the hospital milieu therapy and to bring to the unit for discussion problems current in their home situations.

*This program is operating with the permission and cooperation of Dr. Ralph Patterson, Chairman of the Department of Psychiatry, Ohio State University Medical School, and Director of Columbus Receiving Hospital.

Submitted May 8, 1953.

The Author

Dr. Rond, Columbus, is a member of the attending staffs of Columbus Receiving Hospital and University Hospitals; assistant professor, department of Psychiatry, Ohio State University College of Medicine.

Descriptively, our Day Hospital is an open unit to which the patients, both the men and women, come in the morning and from which they leave in the evening. It is available to any patients who are not too ill and who may safely remain in their home and community while they receive psychiatric treatment. There are many patients who need more intensive therapy than is available in the Outpatient Clinic and yet do not need to be hospitalized behind closed doors. There are many patients who may leave the closed hospital units sooner when there is a place in the hospital system where they can receive hospital follow-up treatment during the day while being with their families at night.

There are patients whose emotional problems are aggravated by the closed door. Some patients have to be weaned gradually from full time hospitalization back into the community. For these and other reasons, the Day Hospital unit is valuable and useful. The Day unit program at the Columbus Receiving Hospital has been set up to serve the other units in the Receiving Hospital, various other services in the Medical Center such as the Rehabilitation Service, various community agencies and the doctors in the area.

ECONOMICAL OPERATION

The Day Hospital unit is more economical to operate than a regular mental hospital unit. It requires only one shift of personnel instead of the usual three; the patients eat only one meal at the hospital's expense and such things as the laundry costs are minimal because the patients are not assigned to beds. Since most mental hospital patients spend only the night in bed, the Day Hospital makes for a better utilization of available space. The rooms ordinarily used for beds can be used for recreational therapy, occupational therapy and other adjunctive therapies.

DAILY SCHEDULE

Our program in Columbus is specifically designed to intensify and integrate all facilities into a closely knit functioning unit. The day consists

of the following: The patients gather at 8:30 a.m. as an informal group and over coffee discuss their experiences since the previous day. A psychiatrically trained nurse is present at this get-together and tends to lead in the discussion. From this meeting are gleaned many points leading to our better understanding of the individual patient.

The hour from 9:15 a. m. is spent in occupational therapy; from 10:15 to 11:00 a.m. the patients are seen by their individual therapist, if this is requested by the patient. Also, this is the time set aside for various physical procedures. At 11:00 a.m. the men and women gather in groups, according to sex, for group interview psychotherapy led by one of the doctors on the staff.

After lunch, at noon, there is a period of rest during which time the patients may read the available pamphlets on Mental Hygiene or a book of their own choosing, or lounge and talk among themselves. From 2:00 to 3:00 p.m. there is recreational therapy which is led by the nurse or an occupational therapist. At. 3:00 p.m. there is mixed interview group psychotherapy composed of both men and women. The unit closes at 4:30 p.m.

Practical talks from the dietetic and social service departments are offered once a week at appropriate times and with relevant material being presented. It is important to note that individual therapy is made available only upon request of the patient, with rare and occasional exception to this policy. To the present, this has seemed to work out satisfactorily and we hope to report more on this at a later date.

INITIAL CLINICAL EVALUATION

All of our patients have an initial clinical evaluation and all receive projective psychological tests. This latter is to clarify further diagnostic thinking and because we are interested in personality evaluation for future research. Also, all patients receive a complete physical evaluation upon entering the program. Social Service has contact with every patient's family on the unit and it participates actively in the overall planning and handling of the patient. The relatives of the patients meet once a week as a group with a member of the Social Service Department.

VOLUNTARY MEMBERSHIP AND ATTENDANCE

The patients have ranged in age from 19 to 62 years, with the majority being in the middle range, 25 to 45 years of age. For the most part they have been severely disturbed neurotics, with a few psychotics (chronic or recovering from an acute episode). They are admitted on a voluntary basis and we tend to emphasize this.

In the event of absenteeism efforts are made to contact patients through the Social Service Department but no force is brought to bear on them to continue in treatment. This latter attitude places the responsibility for the patient being on the unit on his family and himself. It undercuts any idea in the patients that the unit staff wants to control them in any way but that we are only offering them psychiatric aid if they choose to accept it. Thus, an effort is made to create a desire for help in them and show them that they are going to be treated as free persons with all of their rights intact. As they become a member of the social milieu of the unit they are allowed, except for minimal direction, to participate in their own way and to go at their own pace in their progress toward recovery.

No strict limits are set on the patients except those needed to maintain some order and direction in the program. They come and go pretty much as they please. An effort is made to create some responsibility in them for calling the unit on the days they do not come in, and in general this has been successful. They maintain a fairly regular attendance even in inclement weather.

The patients on the Day Program unit may be divided into those who come directly to the Day Unit from the community, and those who come from the closed units in the hospital. The direct admission Day Unit patient is somewhere between the clinic type patient and the closed unit patient, being closer to the closed unit type patient. In the absence of a Day Hospital Unit, these people would undoubtedly be admitted to a closed unit. The transfer admission Day Unit patient may be a recovering patient who, because of the availability of the day unit, may leave the closed unit sooner than otherwise; or a patient who has been readmitted to one of the closed units of the hospital because of a relapse felt to be due to insufficiently close post-hospital follow-up.

ATTITUDE THERAPY

The main approach, as I have said before, is a milieu type of therapy in which attitude therapy by the staff, spontaneous group formation, interview group psychotherapy, and occupational and recreational therapy play the major role. By attitude therapy is meant meeting the patient's needs in a consistent planned manner by all the members of the staff.[4] This is obtained through daily staff conferences in which day by day events on the unit are discussed and in which the individual therapist contributes information which is pertinent to a given case.

Needless to say, the feelings of the individual staff members toward each other is most important, inasmuch as it can reflect on the patients for better or worse. These feelings can be handled at the staff conferences.[5] The importance of the attitude of all the personnel on such a program was pointed up on the occasion of a change of the aides on the unit. The unit had opened with a kindly, warm, non-aggressive negro woman aide working with the patients. She was

replaced by a white woman aide who was more aggressive and directing in her relationships with the patients. The patients referred to this latter aide as a "mother hen." They developed resistances against this behavior on her part and verbalized negative feelings about it in the interview group therapy.

SPONTANEOUS GROUP FORMATION

Spontaneous group formation is utilized in much the way Bettelheim and Sylvester described its use with children they have in a living-in situation.[6] The attitude of the group is allowed maximum play, the interaction of the members is interfered with as little as possible, and utilized to its fullest extent therapeutically. Our initial impression is that behavioral changes and emotional learning in individual patients which result from spontaneous group formation and group attitudes is as effective as insight obtained in individual therapy carried on at a supportive relationship level.

INTERVIEW GROUP PSYCHOTHERAPY

Our interview group psychotherapy is conducted as follows: The patients are divided into separate groups according to sex, regardless of diagnostic label, for 50 minute sessions, four times a week. The patients meet in mixed group psychotherapy three times a week, i. e. men and women together. They are encouraged to be spontaneous in bringing up material for discussion and are allowed to associate to the subject matter in a free manner except where it might be too anxiety provoking.

In the homogeneous groups of the same sex, the discussion has been quite free with a variety of topics being spontaneously brought up. The one frequent topic in the men's group has been problems related to work and family responsibility. In the women's group it has been hostility to men and problems of responsibility of their children.

In view of the fact that all groups are open groups into which patients may enter at any point, and from which they may discontinue at any time, the level of group discussion has never become as deep as it might in the closed type of formal interview group therapy. The final working through of deep emotional problems is consequently left for their individual therapy. However, many patients do not need such help to make a symptomatic recovery.

The main role of the group therapist has been to stimulate discussion, but circumvent material that would be too traumatic; to prevent, or keep to a minimum, discusion which is obviously of a resistance nature and to make appropriate interpretations where indicated.

The mixed group meetings of men and women have been carried mainly by the women. The men have been less active contributors. Their sitting back has seemed to be partly due to a feeling of superiority to the women and partly to the associated fear of becoming emotionally involved in the discussions in some way, such as tearful, and thus revealing a felt weakness. The women have chided them for their seeming indifference to participation, to no avail. The therapist's repeated efforts at drawing the men out has met with only fleeting success. In many sessions the men have taken seats in a continuous row opposite the women, lining up as it were.

In the women's group, the therapist is a man and the recorder is the unit charge nurse. This latter has, we feel, created a mother-father situation for this group of patients, which we hope to report on in the future. In the men's group, the therapist is a man and the recorder is the intern rotating through the psychiatric service.

In the interview psychotherapy groups, the patients sit in a circle, in comfortable chairs, in a well lighted room, the size of which brings the patients within comfortable conversational speaking range. The therapist occupies a seat in the circle with the patients, and tries to neither take the same seat every time nor sit close to the same person.

CASE REPORT

By way of clarity, one case which is descriptive of the approach on our Day Hospital Unit, is presented.

Patient X was a rather large, aggressive, 62 year old, successful, white professional business man who was admitted to a closed unit of the hospital just prior to the opening of the Day Unit. He had a severe incapacitating tic which consisted of a marked jerking of the entire upper half of his body with an accompanying expiratory grunt. His symptom was alleviated while on the closed unit but recurred four days after his discharge and readmission to the closed unit was necessary. Here his symptom was again brought under control and he was transferred to the Day Unit.

On the Day Unit he was aggressive and frequenty hostile, pushing himself to the head of the line in front of the women patients at the cafeteria, cheating at cards and being generally vociferous during the recreation periods. The patient group was cold and rejecting of this behavior and finally effective in helping to produce a change in it. The attitude of the staff was to be firm but non-interfering except when it seemed necessary to maintain some order. Eventually, as he changed, he became the leader of the group and was accepted by all the patients. He related well in the formal group psychotherapy sessions, and his changed behavior paralleled his developing a better relationship with his individual therapist, which led to his working through previous unexpressed material.

Interestingly, during his stay on the unit, an athletic adolescent with anxiety was admitted to the program. He created an uproar on the unit for a while and his athletic prowess was a threat to our patient X. The group attitude again was effective in producing a change in behavior in this adolescent. Patient X, during the period when his leadership was being threatened, appeared

one day wearing on his watch chain medals won for sports achievements in his college days some 40 years previously. He continued to wear them daily throughout the rest of his hospital stay. He reluctantly accepted sharing the limelight with the adolescent.

It was felt that here was an aggressive compulsive man of retirement age who was finding it difficult to give up gracefully and share some of the responsibility of the home with other members of the family, especially his wife. On our unit he had a corrective living experience, gained some understanding of his problem and so was able to make a satisfactory readjustment to his changed life circumstances. This patient was in treatment 13 weeks and follow-ups reveal that he is continuing to adjust well in a mildly compulsive way.

SUMMARY AND CONCLUSION

A Day Hospital unit has been formed with the major emphasis being on milieu therapy, which consists of attitude therapy, spontaneous group formation, formal interview group psychotherapy, recreational and occupational therapy. All indications point to the fact that it is of significant value in the treatment of the mentally ill. The chief value of milieu therapy, in a Day Hospital setting, seems to lie in the fact that it offers a "corrective emotional living experience" to the patient. It provides a type of therapy which lies between that offered by the closed hospital unit and that offered by the outpatient clinic, and which approaches more closely the normal living situation of the patient.

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Treatment of Exudative Diseases With Cortisone and ACTH

Cortisone and ACTH are useful in treating a host of proliferative and exudative diseases for which no specific therapeutic agents are available. They cure none of them. These include the collagen diseases, inflammatory and allergic diseases of the eye, diseases of hypersensitivity, ulcerative colitis, sarcoidosis, chronic pulmonary inflammatory diseases such as berylliosis, psoriasis, pemphigus and segmental enteritis. When the disease is self-limited as in the case of serum sickness, a short course of therapy is adequate. In chronic diseases, such as periarteritis nodosa or rheumatoid arthritis, prolonged suppressive therapy is required.—Robert C. Manchester, M. D., Seattle; *Northwest Medicine*, 52:825, Oct., 1953.

Foods Rendered Sodium Poor By Soaking in Water

The daily sodium intake can be held to 100 miligrams or less. The diet is palatable and variable.

In the removal of sodium by the soaking method there is a loss of any water soluble vitamin which the foods may have contained. Some of the meats, fish, eggs and vegetables contain vitamin A that is soluble only in oils. The water soluble ones, chiefly thiamin, riboflavin, ascorbic acid and niacin are all lost in such long immersion in water, and those vitamins should be replaced with capsules containing at least the following: vitamin A, 10,000 U. S. P. units; vitamin D, 1000 U. S. P. units; thiamin hydrochloride, 3 mg.; riboflavin, 4 mg.; nicotinamide, 25 mg.; and ascorbic acid, 100 mg.

One must keep in mind that there are only five vegetables that need to be soaked in water: lettuce, celery, carrots, beets and spinach. The rest of the vegetable family and all fruits are normally permissible, and all the water soluble vitamins that the body needs are contained in these vegetables. Although these vitamins are lost by the soaking method, the authors believe that they can be supplemented by vitamin capsules containing no sodium. A number of pharmaceutical houses make such capsules.

A loss of potassium by soaking food may be disregarded inasmuch as potassium is contained in the natural vegetables and fruits allowed. Similarly, other minerals and carbohydrates are supplied by the natural foods that are permitted. —George G. Ornstein, M. D., and Lawrence Lercher, M. D., New York City; *J. Med. Soc. New Jersey*, 50:294, July, 1953.

Quinidine Intoxication

The dangers of quinidine have been recognized since its use as an antipyretic drug in the nineteenth century. Amongst the side effects noted are fever, fall in blood pressure, nausea and vomiting, diarrhea and thrombocytopenia. However, the chief hazards of quinidine have long been considered to be arterial embolization, ventricular tachycardia, ventricular fibrillation, and respiratory failure.

Deaths coincident with the administration of quinidine have been reported since its earliest use. Berman and Blumenthal report six deaths in 100 cases of auricular fibrillation treated with quinidine. Smith and Boland report three sudden deaths in forty-one cases, a mortality of 7.4 per cent. However, the advantages of quinidine have been much more widely publicized than the dangers.—Reuben Berman, M. D., Charles M. Sadoff, M. D., and George B. Gordon, M. D., Minneapolis; *Minnesota Med.*, 36:1052, 1953.

The Use of Hydrocortisone-Neomycin Ointment

ROY L. KILE, M. D.

RECENTLY hydrocortisone has become available for clinical trial in the treatment of disease. Hydrocortisone is an adrenal cortical steroid closely related to cortisone both in chemical structure and biological effects. In animals it is about twice as potent as cortisone in such standard assays as the liver glycogen test[1] or the muscle work test.[2] Hydrocortisone has been compared with cortisone in rheumatoid arthritis and found to be more potent by the oral route. Sixty-five to eighty milligrams of hydrocortisone alcohol produced the same antirheumatic effect as one hundred milligrams of cortisone acetate.[3, 4]

Cortisone has been found to be ineffective in dermatitis when applied topically to the skin.[5] This is somewhat surprising in view of the marked activity of cortisone when applied locally to the eye in anterior segment disease.[6, 7, 8] Because of the marked potency of hydrocortisone in animal assays and in rheumatoid arthritis, it appeared worth while to study its effects when applied topically to the skin. Thus far the reported results have been somewhat equivocal.

Sulzberger and co-workers have found that the topical application of hydrocortisone is highly effective in such conditions as atopic dermatitis and contact dermatitis.[9, 10] Goldman,[11] on the other hand, has not observed many of these beneficial effects from the topical use of hydrocortisone in various skin conditions.

In view of the controversial nature of the available reports, it seemed desirable to carry out further observations on the topical use of hydrocortisone.

The preparation used in this study was an ointment containing 2.5 per cent hydrocortisone acetate and 0.5 per cent neomycin.* The antibiotic, neomycin, was included in the formula because of the large number of reports indicating that steroids of the hydrocortisone type tend to facilitate the development and spread of infection, and because secondary infection is a common complication of skin disease. Neomycin was chosen because of its broad spectrum and because it is not widely used for systemic therapy. The latter feature is desirable in that it eliminates the possibility of sensitizing a patient to an antibiotic which may be needed for systemic treatment for some subsequent serious infection.

RESULTS

This clinical study deals with 100 patients having various skin problems treated by the topical use of hydrocortisone. Usually one or two applications were applied per day. This was partially necessitated by a limited supply of the medication in the earlier part of the study and also by the fact that only a small amount of the drug is necessary to produce the desired effect. The results noted occurred rather promptly, usually in the first few days. If there was no improvement in the first few days, usually there was none at all. There were more patients in the series whose skin diseases were favorably affected by the ointment than those unimproved. When it was found that the medication was either not effective or aggravated a condition, treatment of other patients with these diseases was discontinued.

The results are summarized in the accompanying table. Two patients who were sensitive to hydrocortisone developed a definite flare at the points of its application. Ointments prepared with the same base but containing the neomycin were tried in the same area with no ill effects. In one of the two cases, this was done over a period of several months. Then the patient again tried the hydrocortisone-neomycin ointment with a definite flare resulting once more.

In the group of contact dermatitis, there were included four cases of acute dermatitis venenata. The results in these cases were very good. Two of them took somewhat longer than the usual two day period in which one was accustomed to see beneficial effects with this preparation. However, favorable results occurred in three to five days. The relief of itching and improvement was much more marked than by other previously used methods of therapy and no irritation occurred. Even on some patients where little or no improvement resulted, there was relief of itching. Contact dermatitis of the eyelids was particularly improved by this ointment.

COMMENTS

Hydrocortisone-neomycin ointment is a very effective therapeutic tool for certain skin conditions. The most dramatic results were noted in

Submitted September 2, 1953.

*Supplied by The Upjohn Company under the name of Neocortef.

The Author

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*SUMMARY OF RESULTS OF 100 CASES TREATED WITH HYDROCORTISONE-NEOMYCIN OINTMENT

Diagnosis	No. of Cases	Results				Remarks
		Excellent	Good	Same	Worse	
Lichen simplex chronicus	6		1	4	1	
Contact Dermatitis	23	16	4	1	2	Two patients sensitive to hydrocortisone.
Atopic Dermatitis	13	11	2			Relieves pruritus.
Infectious Eczematoid Dermatitis**	40	29	7	2	1	Relief prompt. Some recurrences.
Lupus Erythematosus (Edematous Type—Face)	2		1	1		
Psoriasis	3			2	1	Relief of pruritus in one.
Alopecia Totalis	1			1		
Alopecia Pseudopalade	1			1		
Pruritus Ani	1		1			
Dyshidrosis	3		2	1		
Lichen Planus	1			1		
Pilonidal Cyst	1			1		
Seborrheic Dermatitis	2		2			
Perleche	1			1		
Stasis Dermatitis with Ulcer	1			1		
Recalcitrant Pustular Eruption, Palms and Toes	1				1	
Fox-Fordyce Disease	1			1		
Lichen Sclerosis et Atrophicus	1			1		
Insect Bites	1			1		
Sarcoid	1			1		
Nuchal Dermatitis	1			1		
Total	105	56	20	21	6	

*Five patients had more than one skin problem treated.
**Mostly patchy vesicular hand lesions. Many would fall in category of nummular eczema.

the patchy, vesicular dermatitis that occurs on the hands. Some of the patients had had their skin problem for a period of years. The results were almost dramatic with improvement in a few days and 90 per cent clearing of the eruption within a week. It is the author's feeling that this probably is the commonest skin condition exhibiting a prompt improvement in most of the cases. True, there were a few patients in whom such results did not occur, but by far the majority of them improved in a dramatic fashion even when small amounts of the ointment were applied.

The other groups of skin diseases presenting good results in a large percentage of instances were those of patients with contact dermatitis or atopic dermatitis. Well over two-thirds of the patients in both groups showed improvement that was considered excellent. These results compare with those of Sulzberger, and Witten,[10] but differ from those of Goldman.[11]

The drug was tried on many other skin conditions, but proved much less effective. In a few, some improvement did occur. Examples are seborrheic dermatitis and pruritus ani, but the results were not as dramatic. A disease deserving special mention is psoriasis. No improvement occurred and, in fact, one or two cases became worse. In one case there was much less itching, but other than this, there was no improvement.

CONCLUSION

Hydrocortisone-neomycin ointment is an effective preparation for certain heretofore stubborn skin conditions. The results are dramatic in some. Recurrences do occur when the drug is stopped. After its continued use, however, there seems to be a more permanent effect. In the author's experience, some chronic skin conditions have made prompt recovery when response had been exceedingly slow to any previously used therapeutic agent.

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The Treatment of Pyogenic Skin Infections With Ilotycin® Ointment (Erythromycin)

IRVING L. SCHONBERG, M. D.

ILOTYCIN® (Erythromycin crystalline 10 milligrams to the gram of ointment vehicle) was employed in the treatment of 53 cases of pyogenic dermatoses. Included in this series were:

FIFTY-THREE CASES

6	cases	of	Folliculitis
10	"	"	Impetigo
3	"	"	Sycosis Barbae
5	"	"	Infectious Eczematoid Dermatitis of the ears
6	"	"	Superinfected Atopic Eczema
23	"	"	Infected Dyshidrotic Eczema, Contact Dermatitis and Epidermophytosis

TREATMENT ROUTINE

Crusts were removed with soap and water, followed by three or four applications of the ointment. In the infected eczemas the ointment was applied twice daily. In some cases where exudation and edema existed, wet dressings of potassium permanganate or boric acid solution preceded the ointment. In sycosis barbae, the ointment was applied before and after shaving and again at bedtime.

THERAPEUTIC RESULTS

1. **Impetigo:**
   In all cases the results were excellent, with complete cure in 4 to 8 days.
2. **Sycosis Barbae:**
   Excellent. Cleared in two weeks and have remained well, although occasional use of the ointment is necessary for maintained result. All three cases had been previously treated with x-ray, other antibiotics, quinolor® and vioform® without benefit, and were cases of long standing.
3. **Infectious Eczematoid Dermatitis of the ears:**
   These had been previously well treated with x-ray, other antibiotics and antiseptics, (vioform® and mercury). There was notable improvement after one week, which in all cases has been maintained for one month.
4. **Folliculitis:**
   The acute type responded within a week or 10 days.
5. **The Infected Atopic Eczemas and Super-Infected Dyshidrotic and Contact Dermatoses:**
   These presented improvement insofar as the infectious elements were concerned. The basic processes of oedema, vesiculation and itching remained unaffected.

Submitted July 27, 1953.

The Author

● Dr. Schonberg, Cleveland, is co-chief, department of dermatology, Mt. Sinai Hospital.

SUMMARY

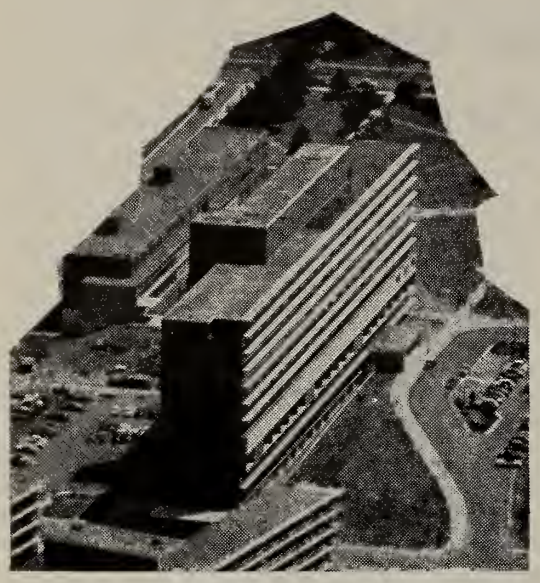
1. Ilotycin® ointment was employed in 53 cases of pyogenic dermatoses.
2. The therapeutic results were excellent in impetigo, sycosis barbae and infectious eczematoid dermatitis of the ears.
3. Ilotycin® ameliorated infected atopic eczemas, infected contact and fungus dermatoses, but had no effect on the basic process.
4. There were no hypersensitivities encountered in this series.

Therapeutic Dermatitis

Therapeutic dermatitis is a cutaneous eruption brought about by inappropriate treatment. It may be produced through many avenues. It may be due to the desire of the patient to "heal himself," or it may be iatrogenic.

The patient with a skin disorder can be spared much trouble if we teach him that his efforts to treat himself may do more harm than good. Much can be done to enlist the cooperation of the pharmacist in this educational campaign. He must be constantly reminded of the responsibility he assumes, as well as of the untoward reactions he may produce, by prescribing over the counter. Finally, we physicians must be more selective in our choice of therapeutic agents, striving to avoid sensitizers and chemicals that are likely to provoke untoward reactions. We must recognize the underlying causative factors in various skin eruptions and direct our efforts toward eliminating them instead of depending on palliative measures alone.

Once damage to the skin has been produced, time will be required for repair. Too drastic therapy usually prolongs rather than shortens the course of the cutaneous disorder. We must be more critical in our appraisal of many new agents, and we should never lose sight of the merits of the philosophy that "if we can do no good, be sure we do no harm."—George W. James, M. D., Winston-Salem: *North Carolina M. J.*, 14:276, July, 1953.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Edward Goodsitt, M. D., President

Presented by L. M. Keith, M. D., and E. von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 50 year old white male, who was known to be a very heavy cigarette smoker, was apparently asymptomatic until two and a half years prior to his final admission, when he began to note that his fingers became very cold and numb when he was out-of-doors even when he wore gloves. About a year later he developed tingling, pin-prick-like parathesia, numbness and sensitivity to cold of the distal portions of the fingers of the right hand, most marked in chilly weather. Similar symptoms soon appeared in the left hand.

About three months later he began to note transient bluish discoloration and burning sensation in the fingertips in the early morning. He first consulted a doctor about seven or eight months later when the skin of his fingertips became very dry and began to slough. The right index finger soon became black and burning pain developed. Two weeks later all of the fingers of both hands except the third and fourth on the left hand began turning black and the nails began to peel. At about this time throbbing pain developed in the right great toe, which shortly thereafter became blue and very tender.

FIRST ADMISSION

He was first admitted to University Hospital six months before his death. At that time he had dry gangrene of the distal phalanges of all fingers except the third on the left and early gangrene of both great toes. Oscillometric readings were considered to be normal and did not change following sympathetic block. Skin temperature determinations were not reliable. A bilateral lumbar sympathectomy was performed.

The second admission was two months after the first. There had been progression of the gangrene involving the hands, and all the toes of both feet were gangrenous. A left mid-thigh amputation was performed. One week later all distal phalanges of both hands were amputated.

The third University Hospital admission was three months after the second. At that time the gangrene of the left hand had progressed and an amputation was performed at the junction between the middle and distal one-thirds of the left forearm. After this time he had severe pain and the right hand became progressively more gangrenous to a point of complete dryness and blackness. The stump of the left forearm broke down, allowing the bones to protrude. The ulcerations on the right leg had progressed.

FINAL ADMISSION

His final admission was about two months later. At that time he had abdominal pain with nausea and occasional vomiting which he had had for about three weeks. The gangrenous processes of his extremities had progressed and he suffered excrutiating pain.

Physical Examination: On physical examination at the time of final admission the temperature was 99, the pulse 90, the respirations 20, the blood pressure 112/74. The patient was an emaciated middle-aged white male who was constantly plagued by severe pain. The heart was not enlarged and no murmurs were audible. The abdomen was soft, non-tender and no masses were palpable. There was mumification of the entire right hand. Ulcerations were noted on both elbows. The amputation stump of the left forearm had broken down with protrusion of the radius and ulna for a distance of approximately 1 to 2 cm. There was a well-healed mid-thigh stump on the left. From the mid-portion of the right leg down there were numerous areas of ulceration.

Laboratory Data: On admission the red blood count was 3.77 million, hemoglobin 10.2 Gm., white blood count 13,900 with 88 per cent neutro-

phils. The urinalysis revealed a trace of sugar and an occasional white blood cell per high power field. The serology was negative for syphilis. A swab from the leg ulcer showed many Staphylococci aurei on smear and culture.

Hospital Course: On admission the patient was placed on saline soaks to the right foot, leg and left forearm stump. He was placed on codeine, 1 grain every three hours, as required, for pain. Two days before his death the patient suddenly became irrational. The nurse remarked that the patient seemed to be having auditory hallucinations. Approximately three and a half hours after the onset of these symptoms the patient had a large, foul-smelling, liquid stool involuntarily. At 4 a. m. the following day the patient vomited his medication plus some undigested food. Shortly thereafter he developed moderate diaphoresis. At 8 a. m. he complained of nausea and vomited about 500 cc. of thick brown vomitus. He became oriented again but nausea and vomiting continued. On the following day the patient complained of roaring in both ears. Shortly thereafter the respirations suddenly became shallow and ceased a few minutes later.

CLINICAL DISCUSSION

DR. LUTHER KEITH: I had a transient experience with this patient during one of his previous short admissions but I did not see him during his last hospital admission. There are a few points in his history I wish to emphasize since they seem to me to play an important part with regard to his disease.

Our patient was by occupation a painter who worked outside a good part of the time. By habit he was an inveterate smoker and smoked about three packs of cigarettes a day. All during these various hospital admissions, during his painful and tragic disease, the patient refused adamantly to stop smoking and continued to smoke at the same rate each day.

His illness started in the winter of 1948 when he first noticed hypersensitivity of his fingers to cold and started to wear gloves. But in spite of this he would notice considerable pain with discomfort and cyanosis in his fingertips while holding the paint brush. In the fall and winter of 1950 he noticed an increase of the burning pains, the numbness and cyanosis of his fingertips and was unable to hold his paint brush during colder weather.

His first admission to this hospital was in November 1951, at which time he had dry gangrene of all the fingertips except the left index finger. He had incipient gangrene in the right great toe the onset of which antedated his first admission only a few days. In spite of all these gangrenous changes his peripheral pulsations were quite good and all his oscillometric curves were essentially normal. The surgical treatment during the first admission consisted of a bilateral lumbar sympathectomy and a right upper dorsal sympathectomy including about T 1-4. These sympathectomies were performed only because he had had a good sympathetic response to caudal and parvertebral blocks although he had very little change in skin temperatures.

His second Ohio State University Hospital admission was some three months later. At that time there was very little progression of the gangrene in the fingers and the right toe, but he had developed a dry gangrene of the entire anterior one-half of the left foot. At that time we also found the first decrease in any of his pulsations, particularly over the left forearm. The surgical treatment during that admission consisted of a left supracondylar amputation of the leg and amputation of all gangrenous fingertips. He was followed between these admissions in the Clinic and in spite of repeated admonitions he still refused to stop smoking.

On the third admission he had gangrene of the entire left hand and the left forearm was cold and pulseless. The previous amputation stumps were healed. The only significant laboratory finding was a persistent mild eosinophilia up to 7 per cent and a moderate leukocytosis. During this third admission the only surgical treatment was an amputation at the left mid-forearm.

NAUSEA AND VOMITING

At his fourth admission to the Ohio State University Hospital, in May of 1952, he had developed a few new symptoms. There was an intermittent nausea with vomiting which he had noticed for some two or three weeks before admission. He had also experienced episodes of cramping abdominal pain. He had necrosis of the amputation stump of the left forearm, gangrene of the entire right hand and gangrenous ulcers over the right knee and the right lower leg. On about the second hospital day he developed moderate tenderness and guarding over the entire abdomen.

In spite of this guarding and tenderness, bowel sounds were definitely present and he ate well, up until and during part of the second hospital day, although he had involuntary stools and the nurses noted that he became irrational and had some hallucinations. On the third hospital day of his last admission he became disoriented. He vomited twice and had two or three periods of profuse perspiration although his blood pressure remained essentially unchanged.

On his fourth hospital day he vomited again but still continued to eat a small amount and took some fluids by mouth. Interestingly enough, he was observed smoking cigarettes clutched between the gangrenous fingertips. He complained of roaring in his ears about 9:20 a. m. that morning and suddenly expired.

I suppose the most pertinent question we could ask at this point is whether there was anything we could have done about this unfortunate pa-

tient in order to stop the progression of these gangrenous changes in all extremities. Remember that three of his extremities were sympathectomized. I think that as far as his peripheral vascular disease is concerned it must be diagnosed as Buerger's disease. Although the patient is within the proper age group of arteriosclerosis and he is in the upper age limit of patients with Buerger's disease, I think that Buerger's disease is the most likely possibility.

Against arteriosclerosis speak the fact that the gangrene of the upper extremities preceded that of the lower extremities, and that he had two and more extremities involved simultaneously. Arteriosclerosis is more of a hit or miss disease which involves one extremity at one time and another at a later date, and pulsation in the major vessels usually ceases before the development of the gangrene. This patient, however, had good pulsations of his radial artery right up to the time he developed gangrene of his hand. He also continued to have good pulsations in both lower extremities even after supracondylar amputation.

I think the only other diagnosis to be considered is Raynaud's disease. Our patient's history and the primary involvement of the upper extremities is suggestive of this disease. However, I think that this disease usually has a longer period of prodromal or minor symptoms before the development of widespread gangrene. The progression of events for this particular patient was a little bit too dramatic and rapid to suggest Raynaud's disease. In addition, Raynaud's disease usually responds much more satisfactorily to sympathectomy than did this patient.

SYMPATHECTOMY

The only thing we accomplished by his sympathectomy was to retard the gangrenous changes of the hands and possibly of the right lower leg. It could not prevent the amputation in the left lower extremity. So I think we are fairly safe in concluding that this man's peripheral vascular disease was Buerger's disease.

Two other important questions are: What caused his rather sudden demise and what caused his rather obscure and bizarre abdominal symptoms? I do not think that we have enough information on this chart to come to any definite conclusion. All we know is that for two to three weeks before admission he had some intermittent nausea and vomiting associated with some vague abdominal cramping pains which he could not localize very well. He continued to have normal bowel movements even during his hospitalization. I think the two things to be considered are mesenteric thrombosis or localized necrosis in the bowel with perforation and peritonitis.

Against mesenteric thrombosis speaks the fact that his abdominal symptoms were present two or three weeks before his last admission. Even until the day before the patient died he was not in shock, which would have been present in case of an extensive mesenteric thrombosis.

I think the most likely possibility therefore is perforation in the bowel with generalized peritonitis. He did not have very much of a systemic reaction from whatever it was because his temperature and pulse stayed relatively normal until his death, but I am sure you have all seen cases of peritonitis in poorly nourished, debilitated patients which show very little systemic manifestations. In conclusion, I would therefore state that the patient suffered from systemic Buerger's disease with involvement of his mesenteric vessels and perforation of gangrenous bowel.

CLINICAL DIAGNOSIS

1. Buerger's disease with involvement of the mesenteric vessels and perforation of gangrenous bowel.

GENERAL CLINICAL DISCUSSION

Dr. J. L. Morton: The x-ray examination of his skeleton showed a bone atrophy which developed rapidly. The presence of gas in the soft tissues suggests a gangrenous process. At no point do we observe any sclerotic changes in the intima or media of his arteries. Radiographically we dealt with an ischemic vascular necrosis of his extremities and because of the spotty atrophy of disuse in the cancellous bone and because of the widespread involvement, we agree with the diagnosis of Buerger's disease.

Dr. H. B. Merkle: How about the eosinophilia? Does this occur in Buerger's disease?

Dr. Keith: Yes, but his eosinophilia was not very excessive and never over 7 per cent. I am sorry we did not get an arteriogram on this patient. It would have been very interesting.

PATHOLOGIC DIAGNOSIS

1. Thromboangiitis obliterans (Buerger's disease) with involvement of vessels of extremities, heart, mesentery, pancreas and spleen.
2. Infarct of small intestine with gangrene and perforation.
3. Acute purulent peritonitis.
4. Multiple myocardial infarcts.
5. Bilateral pulmonary edema.
6. Emaciation.
7. Surgical absence of the distal one-third of the left forearm and hand, left lower extremity distal to the mid-thigh and distal phalanges of the right hand.
8. Status six months post right thoracic and bilateral lumbar sympathectomy.

PATHOLOGIC DISCUSSION

Dr. E. von Haam: The body was that of an extremely emaciated white male which weighed only 70 lbs. The amputation stump of the left leg seemed well-healed; the amputation stump

of the left forearm showed a gaping opening through which necrotic bone protruded. The right hand was completely mummified and the right toe was black and dry. There were extensive ulcerations over the distal portion of the right leg and over both elbows.

The peritoneal cavity was filled with a foul-smelling thick yellow exudate. Brown fecal material escaped from a small perforation in the small intestine which was in the center of a blackish area. The heart showed small whitish areas of fibrosis. The coronary vessels were only moderately sclerosed.

One portion of the ileum showed a dark bluish-red discoloration with two ulcers which had perforated. Other smaller hemorrhagic ulcers were present in the stomach and the colon. The kidneys did not show any evidence of nephrosclerosis and the aorta and all other large arteries were free of arteriosclerosis. The smaller branches of the vessels of his remaining extremities were thrombosed.

HISTOLOGY

The histologic examination of the vessels confirmed the absence of an arteriosclerotic process. Examination of the mesenteric vessels showed all stages of the thromboangiitis obliterans in the various small and middle-sized arteries and veins of the mesentery. The lumens of the vessels were occluded by recent thrombi or thrombi showing early evidence of organization. The vessel walls were not necrotic but were infiltrated by inflammatory exudate composed of lymphocytes and scattered leukocytes. The internal elastic membrane was well preserved and in many vessels was folded. No medionecrosis, no aneurysm formation was found.

In some areas the arterial wall had a fibrinoid appearance not unlike that of periarteritis nodosa. The arteries were by far more extensively involved than the veins although lesions in the latter could also be found. Examination of the various parenchymatous organs showed vascular lesions similar to those found in the mesenteric vessels in the heart, in the spleen, in the pancreas and in the adrenal. In all instances the absence of any intimal thickening and the absence of any arteriosclerotic patches were quite conspicuous.

On the basis of these findings we felt that we were dealing here with a case of widespread thromboangiitis obliterans, or Buerger's disease. In contrast to the usual distribution of the disease, which is limited mainly to the middle-sized vessels of the extremities, involvement of the visceral organs was quite remarkable. It also appeared that this involvement was of just recent date since most of the lesions in the visceral organs showed the acute type which is usually otherwise rarely observed. The ulcer in the ileum had all aspects of vascular necrosis which had undergone ulcerations.

Typical lesions of thromboangiitis were found in the mesentery close to the infarcted areas. Examination of the heart revealed small thrombi in some of the coronary arterioles which were the site of mild periarteritis. Again no evidence of coronary sclerosis was present. Examination of the lungs revealed an absence of all vascular changes but a diffuse edema congestion.

In summary we may then state that histologically the lesions found in the vascular system of this patient were those of thromboangiitis obliterans, or Buerger's Disease. The unusual feature about them was the marked involvement of the visceral vessels and the numerous acute lesions which were encountered. Although the distribution was much more suggestive of periarteritis nodosa, the histologic type of the lesion definitely excluded this disease, as well as arteriosclerosis or the common forms of endarteritis. The death of the patient was produced by the gangrene of the small intestine which led to perforation and purulent peritonitis.

GENERAL DISCUSSION

DR. E. HARD: Dr. Keith, have you ever encountered a case of visceral Buerger's disease?

DR. KEITH: We have not, but about four years ago we had a case of visceral periarteritis nodosa which looked quite similar to this case and which developed necrosis of the pancreas with chronic pancreatitis.

DR. VON HAAM: Visceral involvement in periarteritis nodosa is very common. In fact a principal difference between the two diseases is that periarteritis nodosa is mostly in the visceral vessels while Buerger's disease mostly involves the vessels of the extremities. The unusual feature about this case is that we are dealing with a typical histological case of endarteritis obliterans with the distribution of a periarteritis nodosa.

MEDICAL STUDENT: Is one cigarette considered as harmful in this condition as many cigarettes?

DR. VON HAAM: We feel that smoking has an accelerating effect on any case of Buerger's disease. However, people who prove sensitive to tobacco proteins by the patch test are especially prone to get worse by smoking even a few cigarettes. Individuals who give a positive patch test therefore should quit smoking entirely.

DR. MORTON: What is the present status concerning the etiology of Buerger's disease?

DR. VON HAAM: The most widely quoted theory is that an infection of some type is responsible for the disease. Three facts are always quoted for the support of this theory: the surgeon who pricked his finger while amputating a leg with Buerger's disease and developed a similar disease in his finger; the possibility that Buerger himself produced similar lesions by implanting a fresh thrombus from a case of thromboangiitis obliterans to the arm veins of several

volunteers; and the reports that streptococci have been cultured from acute lesions. However, we feel that infection alone does not explain this peculiar reaction entirely.

First of all, we know that the infection is never systemic since no systemic reactions such as fever, leukocytosis, positive blood culture, etc., have been observed. We also definitely accept some hereditary or racial background since the disease has been reported in identical twins, in members of the same family and in a slightly increased amount among the Jewish males. Finally, we know that smoking definitely adds to the progress of the disease. It is therefore most likely that the condition has an allergic hereditary background similar to the collagen diseases or rheumatic fever and that the disease may be elicited by some type of infection but that the other factors strongly influence its course and progress.

MEDICAL STUDENT: In the case of this particular individual, could nothing have been done to stop him from committing suicide by continuing to smoke?

DR. VON HAAM: I do not know how blunt the physician should or must be to warn a patient of some imminent danger. However, even a statement that he was smoking himself to his death may not have been effective, like many a drinker who is told repeatedly that he is drinking himself to his death and does not heed the warning.

REFERENCE

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Meaning of Diagnosis

It is interesting to pause for a moment and to look at this Greek word diagnosis. To the Greek it meant to know through and through, that is, to know thoroughly. Thought, therefore, should correspond with thing. And how is this correspondence to be brought about? Obviously in two ways; first, by the careful selection and observation of the facts, not all facts, but significant facts; and secondly, by their truthful interpretation. Now a fact is something that has happened, is now happening or can be made to happen; and before this gathering, I need not insist on how difficult it is to get at the facts.

As Mr. Wilfred Trotter, the famous English surgeon was at great pains to impress constantly upon his medical students, "facts, unfortunately, are not the natural diet of the mind. They are laborious and often undignified to collect; they are apt to be formless, ugly and even nasty, they dirty the fingers, they smell and sometimes bite. . . ."—John E. Donley, M. D.; *Rhode Island M. J.*, 36:436, August, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Olecranon—This large process at the upper extremity of the ulna received its name because of its shape, which gives it the fancied appearance of a helmet covering the end of the ulna. The term is derived from the Greek words "olene" or elbow and "kranos" or helmet.

Raphe—This is a descriptive Greek word meaning a "seam," which is applied anatomically to any parts which look as if they had been sewn together.

Inspire—When we inspire, we breathe in and this is the literal meaning of this word, which is composed of the Latin words "in" or into, plus "spirare" to breathe. Hence, when we say that someone is divinely inspired, we are saying that "God has breathed into him."

Instrument—We seldom think of the delicate shining instruments of the doctor as tools, yet this is the literal meaning of this word. It came into English via the French, from the Latin word "instrumentum" or tool. This word is composed of the Latin "in" or on, plus "struo," I build.

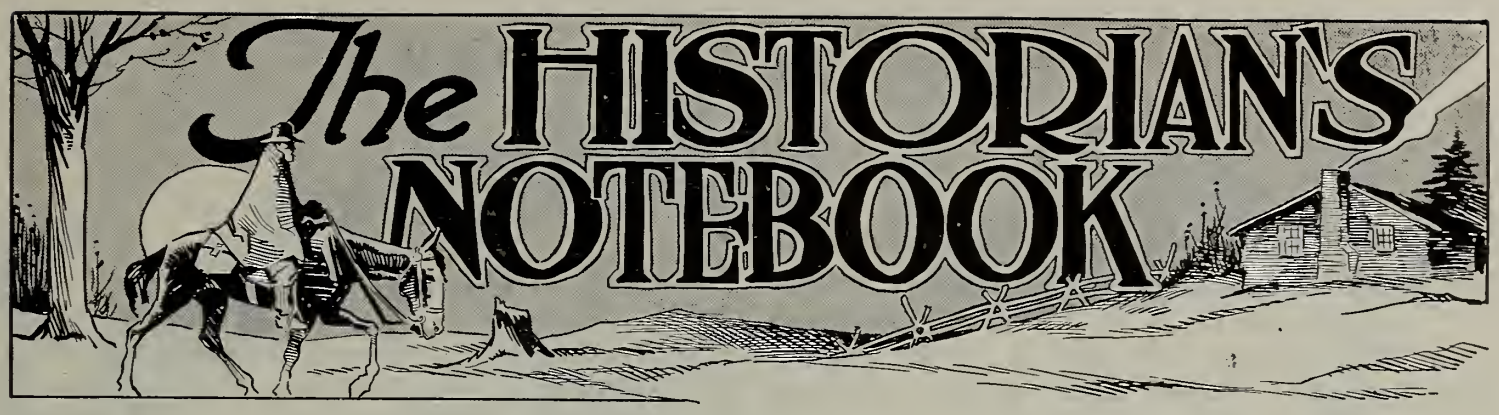
Regimen—This term which designates a guided or systematic course of action or conduct especially as to diet and other living and health rules comes from the Latin word "regere" meaning to rule. Thus when the doctor places you on a strict regimen, he rules your life as though by royal decree.

Relax—Coming from the Latin word "relaxare" meaning to unbend, which in turn comes from the Latin "re" or back and "laxo," I loose or slacken, this term literally means to loosen. Hence by extension it came to mean a diminution of tension or functional activity.

Rhoncus—This Latin word comes from the Greek word "rhongchos" or snoring, and this in turn comes from the Greek word "rhengho," meaning, I snore. This is a descriptive term of ancient usage and denotes an unnatural rattling or wheezing sound which is produced by an obstruction of the air passages. Hippocrates used this term in its Greek form to describe the snoring sounds which he heard in pneumonia and phthisis. In 1819 Laennec adopted the term "rhoncus" and described sonorous and sibilant snoring noises.

Rhubarb—The name of this plant comes from the Latin Rha barbarum. Rha is the old name of the river Volga, in Russia, on whose banks the plant was first found. The Latin barbarum, means foreign or uncivilized. Barbarian is a word imitative of the confused sound of voices of a foreign tongue. Paul of Aegina (625-690) was the first to record the cathartic quality of rhubarb.

—HARRY WAIN, M. D., Mansfield, Ohio.



A Bit of Americana from Trumbull County (An Herb Cutter)

HOWARD DITTRICK, M. D., Cleveland, Ohio

THE pioneer on horseback carried in his saddlebags a variety of crude drugs—herbs, roots and barks. Before the active principles were converted into infusions or decoctions, the drugs were reduced to a convenient size and shape by subjecting them to different mechanical processes. The mortar and pestle, percolator and press are familiar examples, but an ingenious apparatus has recently been donated to the Museum of the Cleveland Medical Library. It merits special mention, since it harks back to the era when Ohio should have attained the dignity of statehood.

Among the equipment used were herb cutters, the first of which came to the Museum as a loan by the Petersilge drug store, founded 1880. It resembled the old cutting box used for cutting corn stalks for feeding cattle. Carl Schmidt of the Archwood Pharmacy donated an herb cutter which resembled a large coffee mill, with an urn-shaped receptacle and a large wheel operated by hand. John D. Gehrung, who held a low state license number (I believe it was 9), presented a rather complicated type. A two gallon tin can was fitted with an eccentric cutting mechanism that worked up and down with a circular movement. It was operated by a crank on the side of the can.

The herb cutter was usually seen in the drug store. A drug store was not always accessible, however, and the progressive physician would often acquire a cutter for his own use. Such was the unusual piece of Americana, donated by Dr. Mary Baker Davis of Newcastle, Pa., through Dr. Lorna Spenzer of Cleveland.

This herb cutter is mounted on a bench made of a convexo-plano plank supported by four legs fitted into it as in the old milking stool. In the center of the flat upper surface, the plank is hollowed out to accommodate a heavy boat-shaped piece of cast iron. A peg at one end of the iron fits into a hole in the plank to make the attachment more secure. Another hole in the plank provides for the handle of the cutter. This also is a heavy piece of cast iron, disk-shaped, with a square hole in the center to admit one arm of a double wood handle. The handle is held securely in place by a square wrought iron nail. The two ends of the handle are highly polished from frequent use.

The apprentice would straddle the bench, place the herbs in the boat-shaped section and, with each hand grasping an arm of the handle, he would rock the iron disk to and fro to cut and macerate the herbs.



Fig. 1. An early nineteenth century herb cutter recently discovered at Howland Corners in Trumbull County.

The bench came from Howland Corners, and dates back to the early part of the nineteenth century. Dr. J. J. Tyler of Warren recently paid tribute to Dr. John Williamson Seely (1771-1840), the first resident physician in Trumbull County. He entered practice in Howland Township in 1806, two years before Dr. John B. Harmon settled in Warren and four years before Dr. David Long came to Cleveland. Dr. Seely may have been the original owner of this herb cutter.

Submitted August 29, 1953.

A Student Assistant to "G. W."

L. A. POMEROY, M. D.

DURING my senior year at Western Reserve Medical School (1907-08) I acted as student assistant to Dr. G. W. Crile. He had offices with Dr. Bunts and Dr. Lower in the Osborn Building. The student acted as first assistant in operations performed at patients' homes, at out of town hospitals and, rarely, at small local hospitals. During most of this period Dr. Lower had no regular assistant, so that I occasionally assisted him and also Dr. Bunts.

Travel was mostly by train. Dr. Crile often operated at the White Hospital in Ravenna. As a traveling salesman would say in his jargon: "We were accustomed to *make Ravenna* on Monday." There were no first class hotels in Akron, so that a trip to that town often meant waiting for a late evening train to Cleveland.

The student assistant usually prepared the instruments and dressings that would be needed. These were carried in a large bag which also contained a pair of large trays to be used in boiling the instruments. Part of the student's job was to carry this heavy bag. Ether was the usual anesthetic and several cans of this were carried. Rubber gloves were boiled with the instruments and then put on wet, from a solution of bichloride of mercury.

Office arrangements were in charge of a small and efficient nurse, Mary Bernard. If the student assistant would help Mary wash the instruments and gloves after a trip out of town, she would help him with his work in the office as occasion arose.

In some ways the student assistant became better acquainted with Dr. Crile than did the average hospital intern. They were together for meals and for long trips. Dr. Crile did his best to have meals for both of us on time. On entering a house with the family somewhat disturbed by the thought of an operation, he would ask if he might step into the kitchen for a moment to get a glass of milk for him and for me. I soon found out that this meant a full meal, perhaps starting with a piece of apple pie. I was asked to keep track of any money that I spent on these trips. One record for 1907 reads as follows: "Carfare 10 cents, Telephone 5 cents, Loan to Dr. Crile 25 cents."

Dr. Crile even found time, on a train trip, to demonstrate carefully how to tie surgical knots.

One night we returned to the Osborn Building at a late hour. The outside door was locked, and I knocked for several minutes without result. Dr. Crile then knocked on the glass with a silver dollar. The janitor responded promptly and, of course, received the dollar.

One day Dr. Crile was driving a rather old electric automobile when suddenly the battery went dead, when we were in front of an automobile agency. He said, "Let's stop and get a new car." We did so, but later I discovered that the new car had been ordered several days previously and was ready for use.

On one trip to Ravenna I went to buy the tickets. Dr. Crile said, "Be sure to ask for Revanna. Some of these railroad men never heard of Ravenna."

Once I remarked about the short time that he consumed in making a diagnosis of salpingitis. He replied, "Did you see that sporty looking man with the bright red necktie? That was her husband." He always had a prompt reply to any question, even if the answer was rather flippant. I once asked why, in a certain pelvic operation, he had shortened only one round ligament. He replied, "When a lady crosses the street, she usually raises her skirt with one hand." On returning from an operation in Pennsylvania, I asked if his Ohio license was good in that state. He replied, "It is just as good as your license."

This was certainly a wonderful year of training in the art of surgery. However, science was not neglected. The assistant was encouraged to make and to record carefully any observations of his own. If these observations did not agree with the usual routine, they were all the more acceptable.

Submitted August 4, 1953.

The Author

● Dr. Pomeroy, retired, Cleveland, Ohio, is a member of the American Radium Society (president 1939-40); formerly, visiting radium therapist, University Hospitals and former senior clinical instructor in gynecology and in radium therapy, Western Reserve University School of Medicine.

Medical Practice in Babylon

In Babylon, 2,000 B. C., the practice of medicine was regulated in detail by code of law and influenced by the code of medical ethics of that day. There has been so much good, as well as so many inconsistencies, in the profession of all periods that it is difficult to say in which period the profession has been greatest.—James L. Hamner, M. D., *Virginia M. Monthly*, 80:600, November, 1953.



OHIO STATE MEDICAL ASSOCIATION TO RUN SPECIAL TRAIN TO 1954 A. M. A. SAN FRANCISCO SESSION; WRITE COLUMBUS OFFICE FOR DETAILS

YEP, the Ohio State Medical Association is going to offer its members another of those great Special Train trips to the Far West next June when the American Medical Association holds its annual session in San Francisco, June 21-25.

Those who want to join the party should write Executive Secretary Charles S. Nelson at the Columbus Office for complete details. Better do so promptly as reservations will be made on a first-come basis.

Here are a few samples from the Special Train menu which has been arranged—just enough to whet your appetite but to give you an idea of why you'd better sign up for one of the greatest trips ever planned for members and members of their families:

The O. S. M. A. Special—an all-room, air-conditioned train, with lounge, observation and dining cars—will leave Chicago on June 12, headed for Denver. Highspot No. 1 will be the beautiful Royal Gorge. The better part of a day will be spent in Salt Lake City. There members of the party will visit many of the interesting sites of that historic city, including the Mormon Tabernacle, State Capitol, Fort Douglas, etc., and will be taken on a special tour of the Utah Copper Mines. A grand view of Great Salt Lake will be offered from the train as it journeys toward Los Angeles.

Glamorous Los Angeles will be the home of the Special Train party for two days and two nights. Special accommodations have been secured at the Biltmore Hotel, one of the finest in the country. Members of the party will be free to arrange their own fun, frolic and sightseeing while in the Movie Capital.

Leaving Los Angeles, the Special Train will visit beautiful Yosemite National Park, one of the wonderlands of the world, where the party will spend two days and one night, with quarters at the famous Ahwahnee Inn. A tour of the Yosemite Valley has been arranged. The Big Trees, the breath-taking falls, and Glacier Point will be visited. What a two days!

The Special will pull into San Francisco on Sunday, June 20. A. M. A. activities

will start on Monday, June 21. Incidentally, members of the Special Train party if they desire, will be able to obtain San Francisco hotel accommodations through Mr. Nelson who has options on enough rooms in two good San Francisco hotels for members of the Special Train party.

Leaving San Francisco on Friday, June 25, the Special will head for Portland, seeing en route the rugged mountains and picturesque forests of Northern California and Oregon. Arriving in Portland, the party will spend Saturday night at the Multnomah Hotel. Sunday will be another one of those memorable days—a trip up the great Columbia River Highway, stopping off at all points of interest, including Multnomah Falls and Bonneville Dam.

The Special will say goodbye to Portland on Sunday night and start for the grand climax of the tour—Glacier National Park. After an all-day ride Monday, June 28, through the heart of the Rocky Mountains, the Special will pull into Glacier National Park that evening.

The party will have three days and three nights in the Glacier National Park—one night at Glacier Park Hotel and two at Many Glacier Hotel. In addition to some of the greatest scenery imaginable, Glacier National Park offers a wide variety of entertainment—fishing, hiking, horseback riding, boating, motor trips to special points of interest, etc.

Leaving Glacier National Park, the Special Train will make for Chicago, arriving on Saturday, July 3—and home for members of the party.

The trip will be an all-expense tour. The cost per person depending on the kind of Pullman space selected, will approximate $500.00—perhaps a little more or a little less.

Included in the base, all-inclusive costs will be the cost of round-trip railroad and Pullman fares from Chicago and return to Chicago; all meals, except meals in Los Angeles, meals in San Francisco and dinner in Portland; hotels, except hotel in San Francisco; tips to Red Caps, bellhops, waiters; and all sightseeing and entertainment specific in the itinerary.

Inasmuch as the trip is designed for adults, space cannot be booked for children under 12 years of age.

CLIP HERE



Arrangements for Special Train must be made well in advance. Help us by sending your reservation as soon as possible.

Clip this coupon and mail to:

Charles S. Nelson, Executive Secretary
Ohio State Medical Association
79 East State Street
Columbus 15, Ohio

I'm interested in the Special Train. Please send additional information.

Name: .....

Address: .....

.....

Tax Roundup for Physicians . . .

How and When To File Forms Under Various Federal and State Tax Laws, Including Income Tax, Withholdings, Social Security and Others

IT is time for physicians to be thinking about those various tax forms to be filled out and taxes to be paid beginning shortly after the first of the year. This article is published with the purpose of furnishing at least basic information on the following taxes with which most Ohio physicians are confronted:

(1) Federal Income Tax Law, including payroll withholdings on employees' salaries.

(2) Federal Social Security Act including the Old Age and Survivors' Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax Law including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation Law tax, required of those with three or more employees (optional for those with one or two).

(5) Ohio Sales and Use Tax.

(6) City Payroll Tax, applying to residents of cities which have enacted such a tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

The data and advice presented were obtained from authentic tax publications and from personal interviews with tax officials.

Nevertheless, physicians are advised to obtain supplemental advice and assistance in the preparation of their returns, from competent tax authorities or from staff members of the office of the District Directors of Internal Revenue or other appropriate agency. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.

FEDERAL INCOME TAX

Basically the same rules under which physicians paid 1952 Federal Income Tax apply to payment of 1953 taxes. The increase in tax liability effected by the Revenue Act of 1951 remains in force through December 31, 1953.

Special provisions are made for those persons who compute their tax for a fiscal year other than the calendar year.

FORMS AND PAYMENTS

Every person whose gross income for 1953 was $600 or more must file certain income tax returns with the District Director of Internal Revenue for his district, not later than March 15, 1954.

Every physician in private practice who comes within the provisions of the Income Tax Law must do the following:

1. File a complete income tax return for the year. He should use Form 1040, either the short form or the long form. The short form may be used only when the gross income, minus allowable business deductions, is less than $5,000 and when the tax is taken from the table. The long form must be used when the adjusted gross income is $5,000 or more or when the taxpayer wishes to claim credit for non-business deductions, such as charitable contributions, personal interest or taxes.

2. Pay the difference, if any, between the income tax paid quarterly during the year, based on the estimated income, and the amount of the tax computed on his final return as of the end of the year. If he has overpaid, the excess amount will be refunded or credited against future tax payments. Amounts refunded carry

interest at six per cent from March 15, 1954, to date of payment.

3. File a declaration of estimated tax for the year 1954, and pay one-fourth of the estimated tax for that year, the balance being payable quarterly thereafter. Blanks for filing the return will be mailed to taxpayers of record by the district Director of Internal Revenue. If estimated returns are based on income of the previous year and the tax computed at the rate for the current year, no penalty will be assessed even though the estimated tax is understated by more than 20 per cent.

For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

Income Tax forms for 1953 together with instructions for preparation are being mailed to taxpayers of record. If a taxpayer desires a more detailed publication, he can obtain a booklet entitled "Your Federal Income Tax" for 25 cents from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Director of Internal Revenue, Federal Building, Water and Gay Sts., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Galia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Director of Internal Revenue, Post Office Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Director of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

EXEMPTIONS AND ALLOWANCES

An exemption of $600 may be claimed by the taxpayer for himself and for each dependent of close relationship. To obtain dependency, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year.

Exemption also is contingent upon the dependent having a net income of less than $600 for the year.

An additional personal exemption of $600 is allowed for those who reach the age of 65 and/or for those who are blind. The additional credits apply both to the taxpayer and/or to his spouse, but not to other dependents.

A taxpayer who sells his residence and buys a new residence within one year of the sale will pay no immediate tax on any gain from the sale of the old house unless he receives more for it than he pays for the new one.

All capital gains and losses are taken into account 100 per cent, but 50 per cent of the excess of net long-term capital gain over net short-term capital loss may be deducted. The alternative capital gains tax is 26 per cent both for individuals and for corporations.

The net capital loss deduction is limited to $1,000 and the disallowed portion of any loss in excess of $1,000 may be carried forward to the succeeding five years.

A person with a capital interest in a capital-type partnership must be recognized as a partner for Federal income tax purposes, even though he receives his interest through a gift or a purchase from another partner.

INCOME-SPLITTING

A husband and wife in many cases may effect substantial reductions by splitting their income on a joint return. On such a joint return, the taxable income (adjusted gross income less optional standard or ordinary deductions and less exemption credits) is divided in half and a tentative tax computed on half of the income. Credits are then applied and the computed tax multiplied by two to arrive at the total tax liability.

HEAD OF A HOUSEHOLD

A "head of a household" may claim about one-half of the tax benefit which is given to a married couple on a joint return because of income-splitting. The head of a household is defined as an unmarried individual, other than a nonresident alien, who maintains as his home a household constituting the principal place of abode and has as a member or members of such household one or more dependents as defined in the provisions.

ADJUSTED GROSS INCOME

Individuals who are employed and receive a salary have no difficulty in arriving at the amount

of their adjusted gross income. The total salary received plus any amounts which might be received from interest or dividends would in such cases constitute the gross income.

The physician in private practice has more difficulty in arriving at his adjusted gross income. From the amount of his cash receipts—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections.

DEDUCTIBLE BUSINESS EXPENSES

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he **cannot** claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. On the assumption that the useful life of an automobile is four years, the government allows 25 per cent of the cost price for depreciation each year. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes. In other words, if an automobile is used only partly for business purposes depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the number of miles the machine is driven in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held **not** to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in **attending medical conventions for a professional purpose** are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Uniforms—The Internal Revenue Department permits deduction of the cost of medical uniforms as a business expense. In general, any apparel used in practice but not suitable for general wear, may be included under this heading.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disburse-

ments" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i.e., all fees, either cash or account are included in income reported for tax purposes) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as ordinary deductions only. All license fees which the physician is required to pay, including narcotic tax and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as an ordinary deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries are also not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are ordinary deductions and not to be taken as business expenses.

Ohio Gasoline Tax—This tax was increased from four to five cents per gallon effective July 16, 1953. The tax is deductible, therefore, to the extent of four cents per gallon through July 15, and five cents thereafter. However, if a physician has already included cost of gasoline as part of his business expenses, the tax is not again deductible. The tax paid on gasoline not used in business is deductible as an ordinary deduction.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as ordinary deductions. Interest paid to carry tax free securities may not be deducted.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is **not** deductible.

ADDITIONAL DEDUCTIONS

In addition to items mentioned in the foregoing paragraphs, the following deductions may be claimed on page 3 of the form:

Contributions, Gifts, Etc.—It is permissible to deduct from gross income, contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an aggregate amount not to exceed 20 per cent of the adjusted gross income.

Medical and Dental Expenses—Deduction is permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of five per cent of the adjusted gross income.

For persons who have reached the age of 65, or for married couples either of whom has reached the age of 65, medical expenses with a limit of $1,250 per person may be deducted. Medical expenses for dependents, other than spouse, regardless of the age of the taxpayer or dependent, may be deducted only if they exceed 5 per cent of the adjusted gross income.

For all taxpayers, deductions for medical expenses may not be in excess of $1,250 per person

claimed as exemption, up to a limit of $2,500 on a separate return and $5,000 on a joint return.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance)."

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

OPTIONAL STANDARD DEDUCTION

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other ordinary deductions is 10 per cent of the adjusted gross income, but not in excess of $1,000.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to **one or more** employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Handbook* after having the employee fill out Form W-4 to determine the number of exemptions he claims.

Since the amount of tax liability changes after the end of 1953, a new scale of rates for withholding purposes will become effective January 1, 1954. A new handbook will be available for this purpose from Internal Revenue Offices.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in triplicate are supplied for this purpose. Two copies are intended for the employee and the third, Form W-2a, is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

DEPOSIT OF WITHHOLDINGS

An employer who withholds as much as $100 per month for the purposes of income tax liability and F. I. C. A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

REPORT OF FUNDS PAID

As in previous years, payments in excess of $500 made during the year for interest, rents or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15 of the following year to the Director of Internal Revenue, Processing Division, Kansas City, Mo.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

Under provisions for coverage of self-employed workers, physicians are specifically excluded, as are certain other professional persons and farmers.

Domestic workers in private homes who are employed by a single employer for at least 24 days in a calendar quarter for which they receive wages of at least $50 are covered. In general, if a person has a maid or other domestic worker for one day in the week, she does not come under provisions of the Act. If a person has such a worker for two or more days in the week she must be covered. Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker becomes eligible after he works continuously for one farm operator for three months and then continues to work for him on a full-time basis on at least 60 different days every three months and earns $50 or more in cash wages every three months.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

OLD AGE AND SURVIVORS' INSURANCE TAX

The Old Age and Survivors' Insurance Tax is payable by every employer who employs **one or more persons in his office** or home.

Through 1953, the employer deducts 1½ per cent of the employees' wages at each pay period and contributes a like amount himself. **Beginning January 1, 1954, the amount is increased to 2 per cent for the employee and 2 per cent for the employer.** (There is considerable talk to the effect that Congress may pass legislation stabilizing the deduction at 1½ per cent, retroactive to

January 1, but unless Congress does take such action the amount is automatically increased.)

The amount is deducted and contributed on the first $3,600 of wages for the taxable year. The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed prior to April 30, 1954, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. If the employer has already enrolled with the Internal Revenue office for payment of Social Security taxes for office employees, he may add his domestic workers to the same Form 941 on which he reports other employees.

Farm workers must be reported on Form 941. They may be reported on the same form with office employees.

FEDERAL UNEMPLOYMENT TAX

The Federal Unemployment Insurance Tax applies only to employers who have had **eight or more persons** on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the Collector of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to $3,000 and is paid exclusively by the employer—the employee making no contribution. (The $3,000 limit is not to be confused with the $3,600 maximum under the old age and survivor provisions.) A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO UNEMPLOYMENT COMPENSATION TAX

In general, employment of **three or more persons** in any one day renders the employer liable for this tax. There are certain exceptions. A physician who is in doubt as to his liability, therefore, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may be reduced to as low as one-tenth of one per cent. Only the first $3,000 paid by any employer to any one individual within a calendar year is taxable.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. Quarterly lists of employees have been discontinued.

OHIO WORKMEN'S COMPENSATION

The purpose of the Industrial Commission of Ohio is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing **three or more** employees regularly in the same business is required to furnish the Industrial Commission with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of **less than three** employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the year. Another requirement of the reports is an estimated payroll for the eight-months periods January 1 - August 31 and July 1 - February 28, respectively.

The main office of the Industrial Commissio is in Columbus. Branch offices are maintained in Akron, Canton, Cincinnati, Cleveland, Dayton, Hamilton, Lima, Mansfield, Martins Ferry, Portsmouth, Toledo, Youngstown and Zanesville.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies, etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent of cost which value should be used as a utility value.

Such returns should be made in duplicate. The

so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

As defined in Section 5701.07 R. C., credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75 per cent, 50 per cent, 25 per cent, 10 per cent, etc., of its full face value, or of "no value" in case that is considered the "actual value" of this account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in 1953 but which have decreased in actual value during that year.

Some physicians misunderstand the provision requiring the listing of accounts receivable for taxation. Some think that physicians are the only ones who have to do so and that the law is discriminatory. That is not true.

Every person who possesses intangible assets, *such as accounts receivable*, or any business or professional man who does business on a credit basis and keeps books, must return his accounts receivable for taxation.

Such person must keep in mind that he can estimate depreciation on his accounts receivable and that he can use *accounts payable* as an offset against accounts receivable, paying the tax on the difference.

Obviously, the percentage discount used by a physician in depreciating the value of his accounts receivable will depend to a large extent on the doctor's collection experience and on the economic status of the majority of his patients. In other words, the physician who has difficulty in collecting bills or whose practice serves a large number of persons in the low-income brackets or who are poor credit risks, should use a higher depreciation formula than the physician who does not have these factors to contend with.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department. **However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15, 1953, for purchases, during the period January 1 to March 31, 1953, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."**

Rule 102 of the Ohio Tax Commissioner applies specifically to physicians and dentists. It reads: "Physicians and dentists are the consumers of the various items of tangible personal property which they use in the rendition of their professional services and the tax will apply upon their purchase of all items of tangible personal property, including equipment. The tax does not apply to the fee for professional services rendered by physicians and dentists. If physicians and dentists apart from their professional services are engaged in selling, to the public such articles as medical supplies, mouth washes, dentifrices and the like, they are venders and must procure a vendor's license and collect the tax on all such sales."

CITY PAYROLL TAX

Several cities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages paid employees. For example, Columbus has a law which requires the employer to deduct one-half of one per cent of the employees' wages and make returns to the city auditor quarterly. A physician who moves into a new location should inquire as to what tax laws may be in force locally.

"Fine Performance" for Medical Education Recognized



Dr. Paul F. Orr (left) presenting AMEF Award of Merit to Dr. Edward J. McCormick, Trustee of the Fred Melvin Douglass Foundation.

The Award of Merit of the American Medical Education Foundation was presented to the Fred Melvin Douglass Foundation of Toledo during the annual meeting of the Northwestern Ohio Medical Society held at the Toledo Academy of Medicine Building, October 14. The Douglass Foundation was founded by the late Dr. Fred M. Douglass, prominent Toledo surgeon who died in 1950.

The presentation was made by Dr. Paul F. Orr, Perrysburg, Councilor for the Fourth District of the Ohio State Medical Association and a member of the 1953 Ohio Campaign Committee for AMEF. Dr. Orr stated that the Award was made to the Douglass Foundation for "its singularly fine performance in behalf of the American Medical Education Foundation."

In accepting the award in behalf of the Douglass Foundation, Dr. Edward J. McCormick, a trustee of the Foundation and President of the American Medical Association, urged all Ohio physicians to make a liberal contribution to the American Medical Education Foundation. He said that whole-hearted support of the project by the medical profession was necessary in order to maintain the upward progress of medical education.

Commenting on Dr. McCormick's appeal, Dr. Wm. M. Skipp, Youngstown, Chairman of the Ohio AMEF Campaign Committee, has said:

"Each Ohio physician has an opportunity to participate in this campaign by responding to a letter sent to him recently by Dr. Paul A. Davis, President of the Ohio State Medical Association. I am confident that members of the Ohio State Medical Association, realizing the serious plight of the medical schools, will not let the cause of medical education down in this emergency."

Are You Planning . . .

to attend the 1954 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION in COLUMBUS, APRIL 12-15? If so, it is an excellent plan to make HOTEL RESERVATIONS well in advance to assure the best accommodations. This list of leading downtown Columbus hotels is given for your convenience. It isn't too early to clip the coupon at the bottom of this page and mail it to the hotel of your choice.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NEIL HOUSE	$5.50-7.00	$8.00-10.00	$10.00-13.00
DESHLER-HILTON HOTEL	$5.00-9.00	$9.00-13.50	$ 9.50-14.50
HOTEL FORT HAYES	$5.50-8.00	$8.50-10.00	$10.00-11.00
SENECA HOTEL	$4.00-6.00	$6.00- 8.00	$ 8.00-10.00
SOUTHERN HOTEL	$5.00-6.00	$6.50- 8.50	$10.00-11.00
HOTEL VIRGINIA	$4.50-5.00	$7.50- 8.00	$ 8.00- 9.00
HOTEL CHITTENDEN	$3.50-4.00	$5.00- 6.75	$ 6.75-10.50

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.

(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 12, 13, 14, 15, 1954, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April ..... at.....A.M..... .....P.M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

.....

Insurance Coverage Growing . . .

Additional Gains Recorded in 1952 by Voluntary Programs Offering Medical, Surgical, Hospital and Accident Protection, Report Shows

"THERE are few parallels in the annals of insurance or other fields that can match the spectacular growth of voluntary health protection in the United States in recent years." So states the Health Insurance Council of the United States in its annual survey of accident and health coverage in the United States as of December 31, 1952.

"The record is more notable," the Council continued, "in view of the pressures for Government-sponsored compulsory plans in the period, and it supplies decisive evidence of what the American people can do on their own initiative and responsibility."

The "unbroken record of progress" of the last two decades was continued in 1952 by striking gains in hospital, surgical, and medical expense protection.

The total number of people with hospital expense protection exceeded 91 million at the close of 1952, a gain of five and one-half million people, or 7 per cent. In 1941 only 16 million people had this protection.

MEDICAL—SURGICAL COVERAGE

Those with surgical expense protection at the end of 1952 totaled 73 millions. The increase for the year was seven and one-half million persons, or 12 per cent. Less than seven million people had this insurance in 1941.

A more recent development in the field, medical expense protection, covered 36 million people at the close of 1952. This constituted a gain of eight million persons or a 29 per cent increase over the previous year. About three million people had this coverage in 1941.

According to the Council, insurance companies and Blue Cross-Blue Shield organizations together accounted for about 94 per cent of all hospital and surgical expense protection last year, and about 87 per cent of coverage under medical expense plans.

The balance was spread among plans provided by industrial employers, labor organizations, community groups, private group clinics and colleges.

Insurance companies provided coverage to a majority of people who had hospital expense protection. At the end of last year more than 29 million persons were covered against hospital expense under group insurance, and 22 million persons under individual hospital expense insurance plans.

The insurance companies also provided the majority of surgical insurance coverages, with nearly 30 million persons under group and 19 million under individual plans; together about two-thirds of all persons covered by this protection. Blue Shield and medical society plans protected about 28 million persons.

Blue Shield and medical society plans continued to lead in medical expense coverage with some 18 million persons or more than half of all persons covered.

MAJOR MEDICAL EXPENSE

Major medical expense coverage, the newest addition to voluntary health insurance plans, is designed to help meet the catastrophic costs resulting from prolonged disability.

Maximum benefits available under this form of protection range from $2,500 to $10,000. It is written with a deductible feature, as is automobile collision insurance. Usually the person covered is a co-insurer of expenses incurred above the deductible amount, requiring him to pay some portion of these expenses.

The purpose of the co-insurance is to encourage the person protected to obtain as reasonably as possible only such health services as are needed, thus keeping down the costs of protection, according to the Council's report.

"Broadly speaking," the report stated, "it takes up where the customary forms of health protection—hospital, surgical, and medical care—leave off. It also covers such costly items as nursing care and use of special appliances."

"The development of major medical expense policies is further evidence of the willingness of the insurance business to experiment in the public interest," the Council said.

At the end of 1952, a total of 689,000 people were covered by major medical expense policies of insurance companies and in addition, others have substantial protection against the catastrophic costs of serious disability. Some hospital, surgical and medical expense plans have coverage for the costs of prolonged disability. Other plans have such high maximum benefits that there is little need for major medical expense policies, the Council stated.

Total benefits paid toward hospital, surgical, and medical costs by voluntary health insurance during 1952 is estimated at about $1.5 billion, two-thirds of which went to hospitals. About $546 million was paid toward the costs of physicians' services.

APPLICATION

For Space in the Scientific and Educational Exhibit

1954 Annual Meeting • Ohio State Medical Association

DESHLER-HILTON HOTEL COLUMBUS, OHIO APRIL 12-15, 1954

Fill Out and Mail to:

GEORGE J. HAMWI, M. D., *Chairman*
Committee on Scientific and Educational Exhibits
Room 1138, University Hospital,
Ohio State University,
Columbus 10, Ohio

DEADLINE FOR APPLICATIONS . . . FEB. 15, 1954

1. Title of Exhibit:_____
2. Description or nature of exhibit (attach 200-word description to this blank).
3. Will radiologic viewing boxes be needed? If so, state number and size:

   Number of boxes needed_____ Size required_____
   (Please indicate if you plan to furnish own view box.)
4. Will you require shelf space? If so, how much?_____
5. How much floor space will you require?_____
6. How much back wall space will you require?_____
7. How much side wall space will you require?_____
8. Other material or equipment required:_____
9. Name of exhibitor: _____

   _____(Street) _____ (City)
10. Name of institution cooperating in exhibit (if desired) :

_____

_____

_____

Booths will have a back wall and two side walls. The side walls of all booths will be four feet wide. The back wall of most of the booths will be 8 feet long; a few will be somewhat smaller. If an exhibitor needs more space, or a space with special dimensions, he should explain in detail in writing to the Exhibit Chairman. In most instances, the standard booth should be sufficient.

The height of the back and side walls will be eight feet. However, because of the standard shelf in all booths, only five and one-half feet of wall space will be suitable for exhibit material.

Military Directives . . .

Selective Service Explains Handling of "Regular" Physician Registrants; Defense Department Issues Rules Implementing New Doctors Draft Law

TWO military directives of importance to physicians were issued recently—one by National Selective Service Headquarters; the other by the Department of Defense.

On October 9, National Selective Service Headquarters issued Operations Bulletin No. 88. It is primarily concerned with the classification and the commissioning or induction of physicians between the ages of 18 and 26 who are classed as "regular" registrants under the Selective Service Act.

The bulletin points out that when additional medical officers are needed, recent medical graduates who are "regular" registrants will undoubtedly be called upon for active duty, perhaps even before the induction of "special" registrants under the Doctors' Draft Act. At present induction of "special" registrants has been temporarily suspended.

The Department of Defense directive, issued October 7 and labeled Directive No. 1205.1, carries administrative regulations to implement the revised Doctors' Draft Law.

SELECTIVE SERVICE BULLETIN

Following is the text of the Selective Service Operations Bulletin No. 88 issued on October 9:

1. Persons who have registered under the provisions of section 3 of the Universal Military Training and Service Act, as amended, are referred to in this bulletin as "regular registrants."

2. Operations Bulletin No. 102 provides that the processing for armed forces physical examination and for induction of special registrants shall be discontinued. While the need of the armed forces for physicians, dentists, and veterinarians is lessened, certain numbers will continue to be needed. It is anticipated that many replacements for physicians, dentists, and veterinarians who will complete their active duty service can be obtained from recent graduates who are also liable for induction as regular registrants.

3. (a) Local boards are therefore requested to continue to process for induction all regular registrants who are also special registrants. Such registrants shall be processed for induction as regular registrants without regard to their priority status as special registrants.

(b) Local boards should continue to give serious consideration to the deferment of a regular registrant who is also a special registrant and who holds a degree in either medicine or dentistry, in order that he may complete up to one year of internship.

(c) Whenever a regular registrant who is also a special registrant is in or is hereafter placed in a class available for military service, the local board shall advise such regular registrant by letter that in order to be eligible for the postponement of induction provided by paragraph 4 of this bulletin for regular registrants who have made application for a commission in a Reserve component of the armed forces he must make such application within 30 days after the date of the letter.

The local board shall enclose with its letter three copies of Initial Data for Classification and Commissioning in Medical Services for Medical, Dental and Veterinary Corps (DD Form 390) and shall further advise such regular registrant that the initial step in making his application for a commission is for him to complete and return to the local board the three copies of that form, indicating in Item 30 thereof his first and second choice of services.

Upon receipt of these forms the local board shall forward them to The Surgeon General, Department of the Army, Washington 25, D. C., Attention: MEDCN-PA, attaching thereto a copy of its letter to the regular registrant which will serve to identify him as a person affected by this bulletin.

The regular registrant shall also be advised that he will be allocated to one of the military departments for commissioning purposes. The letter forwarded to the regular registrant by the military department to which he has been allocated will contain a complete set of application forms and instructions for commissioning by that military department.

4. It is the policy of the armed forces to utilize in a commissioned rather than enlisted status all special registrants who qualify for such commissions. This Headquarters concurs in that policy. Therefore, the induction of a regular registrant who is also a special registrant shall be postponed, under section 1632.2 (a) of the Selective Service Regulations, until further notice, whenever the local board finds that such regular registrant has either (a) applied for a commission in a Reserve component of the armed forces within the period prescribed in paragraph 3 (c) of this bulletin and has not failed to accept the commission when tendered, or (b) accepted a commission in a Reserve component of the armed forces or the Public Health Service prior to the date he is to report for induction.

When such a registrant actually holds a commission in the armed forces, it is to be presumed

that he will be called to active duty at the earliest date his services can be utilized in a commissioned status consistent with the provisions of section 4 (c) of Public Law 779, 81st Congress, as amended. It is also to be presumed that such a registrant who actually holds a commission in the Public Health Service will be called to active duty at the earliest date his services can be utilized.

Such a registrant should be inducted only when he fails to apply for, or to accept when tendered, a commission in a Reserve component of the armed forces and does not hold a commission in the Public Health Service. The military department will notify the State Director of Selective Service concerned in the event that a regular registrant fails to accept a commission within 30 days after the date it is tendered.

DEFENSE DEPARTMENT DIRECTIVE

A resume of the Department of Defense Directive No. 1205.1 has been prepared by the Council on National Emergency Medical Service of the American Medical Association, emphasizing provisions of the directive which establish new policy and those which substantially amend regulations previously in effect. The A. M. A. resume of the directive reads as follows:

A.—The Executive Agent

The Department of the Army is designated as the Executive Agency for the Department of Defense and is charged with the following administrative responsibilities in connection with the new "Doctor Draft Law."

(1) Determining the acceptability of special registrants for military service in accordance with established professional, physical and moral standards;

(2) Maintaining appropriate liaison with the Selective Service System; and

(3) Making departmental allocations of special registrants ordered for induction, following consultation with representatives of other military departments.

B.—Professional Standards

A special registrant (medical) will be considered professionally acceptable if:

(1) He is a graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association or is a graduate of a foreign medical school whose graduates are recommended for consideration by that Council; or

(2) If he is a graduate of any other medical school and possesses a degree of Doctor of Medicine as a result of completing a four-year course of medical instruction; has had 12 months or more of intern or residency training approved by the Council on Medical Education and Hospitals or is a diplomate of an American Specialty Board; and is licensed to practice medicine in a state or territory of the United States or the District of Columbia or is a diplomate of the National Board of Examiners.

C.—Physical Standards

All special registrants will be considered to be potentially acceptable for military service provided they can reasonably be expected to be productive in the Armed Forces. These physical standards are substantially the same as those adopted by the Armed Forces on January 12, 1953.

D.—Moral Standards

A special registrant will be found **not** acceptable for military service if he has:

(1) Been convicted by a Civil Court of an offense where punishment exceeds one year, or of any offense punishable by death, or

(2) A record of difficulties with law enforcement agencies has exhibited criminal tendencies or other traits of character which would render him unfit, or

(3) Previously been separated from the Armed Forces under other than honorable conditions or for the good of the Service, or

(4) Had criminal charges filed against him, alleging a violation of state or federal law, which are still pending.

The fact that special registrants are not commissionable or do not desire or will not accept a commission will **not** preclude them from induction or acceptance in the Armed Forces.

E.—Processing of Requirements

The estimated military (uniformed) requirements will, after processing within the Office of the Secretary of Defense, be referred to the Assistant Secretary of Defense (Health and Medical) who will obtain the comments of the Health Resources Advisory Committee, Office of Defense Mobilization.

The Assistant Secretary of Defense (Health and Medical) will also coordinate the report with the Assistant Secretary of Defense (Manpower and Personnel) prior to referral to the Secretary of Defense for submission to the President. The Assistant Secretary of Defense (Manpower and Personnel) will place approved calls with the Selective Service System.

F.—Commissioning of Special Registrants

Special registrants otherwise qualified may be commissioned under the following circumstances:

(1) Upon receipt of an application from a special registrant ordered for induction and allocated to the branch of the Armed Forces to which the application is submitted;

(2) Upon receipt of an application for appointment and immediate active duty (within 90 days) from a special registrant who is not under orders for induction as a special registrant;

(3) Upon receipt of an application for ap-

pointment to fill a vacancy in the Reserve from a priority 4 registrant with 21 months or more of prior service;

(4) Upon receipt of an application for participation in a professional training program; and

(5) Upon receipt of an application from special registrants who are also liable under the basic Selective Service Act, providing such registrants have, as regular registrants, been placed by their local boards in a class available for military service.

G.—Determination of Rank

The rank assigned will be based upon the number of years spent in appropriate professional activities subsequent to graduation from medical school and prior to date of appointment. The following schedule will apply:

PHYSICIANS AND DENTISTS

Years	Grade	
	Army, Air Force	Navy
Less than 4	1st Lieutenant	Lieutenant (JG)
4 or more but less than 11	Captain	Lieutenant
11 or more but less than 18	Major	Lt. Commander
*18 or more	Lt. Colonel	Commander

*Persons with 25 or more years of professional experience who have achieved national prominence as authorities in their particular specialty may be appointed in the grade of colonel in the Army or Air Force or as captains in the Navy.

H.—Readjustment of Grades

Any physician appointed in a reserve component or now serving on active duty, who would have been entitled to a higher grade if the subject directive or Public Law 84, 83d Congress, had been in effect at the time of his current appointment, will be entitled to an adjustment of grade.

In the case of a reservist, he will, immediately prior to being ordered to active duty, be re-appointed or promoted to such higher grade. A special registrant on active duty will, at the earliest practicable date, be re-appointed or promoted to such higher grade.

Pursuant to the "Doctor Draft Law" appointments to grades higher than Major or Lieutenant Commander can be made without referral of the case to a Board of Officers convened by the Secretary of the Service concerned.

I.—Ordering Commissioned Personnel to Active Duty

(1) Reserve medical personnel will, **insofar as practicable**, be ordered to duty in accordance with the priorities established in the "Doctor Draft Law."

(2) Members assigned to organized reserve units will be called to active duty as individuals in accordance with their priority except when their units are brought into active duty.

(3) Physicians who are members of a National Guard unit will not be called to active duty at this time, (unless the unit is called) providing they were members of such a unit prior to June 25, 1950.

(4) The "essentiality" of medical reservists will be determined by the National Advisory Committee to the Selective Service System. Requests for delay on this basis may be made by a physician or an employer directly to the branch of the Armed Forces involved. An appeal may be submitted directly to the Secretary of Defense in the event a request for such a delay is disapproved.

(5) Any physician qualified for a reserve commission is given an opportunity to volunteer for a period of active duty of **not less than 24 months.**

J.—Inter-Service Transfer

Physicians holding reserve commissions in the Armed Services may apply for transfer to another service. An application containing specific identifying information must be submitted through command channels and must bear the endorsement of the parent and requested departments, irrespective of their approval or disapproval in each case.

RESIDENTS FOR THE 1954-1955 HOSPITAL YEAR

The following information is contained in Information Release No. 10 of the National Advisory Committee to the Selective Service System, which amends Information Release No. 3:

The National Advisory Committee, in considering residents who are special registrants and the Health Resources Advisory Committee in considering residents who are Reserve officers have adopted the following general policy: As has been customary in the past, each case must be considered separately on its merits and delays or deferments to serve as residents are based on the needs of the hospital rather than to permit an individual physician to continue or complete a training program.

Priority I and Priority II—Practically without exception these men should be considered available for service and should not be deferred to accept or to continue in residencies for another hospital year. If they desire to serve the hospital temporarily until such time as they are called, there is no objection, providing it is understood they are not to be delayed beyond the time that they are called to service.

Priority III—(a) Those with double liability: Those Priority III individuals who were under **28 years of age as of June 19, 1953** (now under 28½ years of age) have double liability and may be called at any time as regular registrants in addition to being subject to call as special registrants. They should enter service on the completion of their internship without exception. The Selective Service System has arranged to postpone the induction of such regular registrants, if the registrants apply for and receive

a commission, until the armed forces can bring them to active duty in an orderly manner.

(b) **Those over 28 but under 31 as of June 19, 1953:** They are in the group that should supply the needs of the armed forces and should enter service as soon as they have completed their internship or current residency. If deferments are granted by the local board for this group of registrants and it becomes necessary for the armed forces to ask for a call for physicians, the Selective Service System may have to present physicians of Priority III who are over 31 and who are now actively engaged in the practice of medicine. It is highly desirable that it not be necessary to issue calls for Priority III men who have attained their 31st birthday.

The Committee, in reaching these decisions, has not changed its position since it has repeatedly called attention to the fact that an individual's potential liability for military service should be considered in appointing residents. This applies also to the so-called pyramid system: those individuals selected for advancement to an additional year's service as they rise in the pyramid should be those who are not liable for military service.

It is essential that the hospitals cooperate in this program so that the intent of Public Law 84 be carried out and that members of the professions entering the services are from that group which should go first according to the provisions of that law. Otherwise the calls will be on an inequitable basis from the standpoint of the professions as a whole.

Hill-Burton Hospital Program . . .

As Result of Six Years of Planning, Ohio Is Ahead by 70 Hospital Building Programs Totaling More Than $111 Million in Construction

WITH Federal funds under the Hill-Burton Act tapering off through budgetary curtailment, the Hospital Facilities Division of the Ohio Department of Health is taking a conservative view of the future by reserving all future appropriations toward fulfilling its present commitments.

Those commitments, together with projects already completed under the Hill-Burton Act, include the following additions to Ohio's Hospital and health facilities: 51 projects completed or in use; 18 projects under construction, and one project still in the planning stage. These 70 building programs are detailed in the accompanying progress report list.

During the six years of its operation in Ohio, the Hospital Facilities Division of the Ohio Department of Health has participated in $111,170,000.00 worth of construction, $23,533,824.00 of which was furnished by the Federal government.

Hill-Burton funds have been restricted during much of the program by curtailment of budgetary appropriations. Effective with the fiscal year beginning July 1, 1949, Congress increased the ceiling of appropriations on the national level from the original $75 million annually to $150 million annually, ostensively for a six-year period. However, aside from that one year (fiscal, 1950) annual budgetary appropriations actually never exceeded $85 million in any one year.

The local administrative office, under direction of Anthony J. Borowski, Dr. P. H., has never reneged on any project once it has been approved, in spite of the fact that it has had to project its approval into the future. It is usually well after the start of a fiscal year before the office is notified what its budgetary appropriation will be for that year.

This year Ohio's appropriation of Hill-Burton funds was cut to $2½ million. The local administration had every reason to believe that the national floor would be $75 million which would have made Ohio's share $3 million.

Congress this year enacted enabling legislation to extend the intent of the Hill-Burton Act through fiscal years 1956 and 1957 (through June 30, 1957). Budget appropriations will determine how much is forthcoming for these years.

By not approving any new projects, the office is assured that it can fulfill its obligations on the projects under construction or in the planning stage.

The Journal previously published a list of 33 projects completed and in use. Following are additional projects completed:

PROJECTS COMPLETED IN LATE 1952 AND IN 1953

Union Hospital, Dover, 97-bed general (addition).

Elyria Memorial Hospital, Elyria, 118-bed general (addition).

Chillicothe Hospital, Chillicothe, 51-bed general (addition).

Cuyahoga County Chronic Disease Hospital, Warrensville, 440-bed chronic disease.

Molly Stark Tuberculosis Sanatorium, Canton, 112-bed, tuberculosis (addition).

Marietta Memorial Hospital, Marietta, 58-bed general, (addition).

Joint Township District Hospital, St. Marys, 50-bed general.

Euclid-Glenville Hospital, Euclid, 172-bed general (replacement—old facility to be renovated and used by Forest City Hospital).

Bellevue Hospital, Bellevue, 60-bed general (addition).

Providence Hospital, Sandusky, 40-bed general (addition).

Mercy Hospital Nurses Residence, Portsmouth.

Samaritan Hospital, Ashland, 35-bed general (addition).

City Hospital of Akron, Akron, 75-bed general (addition).

Toledo Health Center, Toledo.

Mercy Hospital, Mount Vernon, 85-bed general (addition).

Health and Safety Center Building, Columbus, health center.

Newark Hospital, Newark, 61-bed general (addition).

Community Memorial Hospital, Hicksville, 16-bed replacement.

UNITS UNDER CONSTRUCTION

The following projects are in various stages of construction:

Alliance City Hospital, Alliance, 71-bed general (addition).

St. Elizabeth Hospital, Dayton, 176-bed general (addition).

St. Charles Hospital, East Toledo, 201-bed general.

Barberton Citizens Hospital, Barberton, 130-bed general (replacement).

Youngstown South Unit, Youngstown, 187-bed general (addition).

People's Hospital, Akron, 172-bed general (addition).

Good Samaritan Hospital, Dayton, 120-bed general (addition).

Green Cross Hospital, Cuyahoga Falls, 50-bed general (addition).

Barnesville Hospital, Barnesville, 50-bed general.

St. Elizabeth Hospital, Youngstown, 200-bed general, (addition).

Fairview Park Hospital, Cleveland, 188-bed general hospital (replacement—old facility will be renovated and used by Lutheran Hospital).

St. Joseph Riverside Hospital, Warren, 52-bed (addition).

Trumbull Memorial Hospital, Warren, 151-bed (addition).

City Hospital, East Liverpool, 77-bed (addition).

BayView Hospital, (Osteopathic), Bay Village, 30-bed addition, complete remodeling.

Massillon City Hospital, Massillon, 82-bed (addition).

Marion City Hospital, Marion, 158-bed replacement and health center to house city-county health department.

City Hospital, Bellaire, 34-bed general (addition).

IN PLANNING STAGE

Still in the planning stage is a tuberculosis hospital for southeastern Ohio; specifications and exact location not yet determined.

New Members of O.S.M.A.

The following are the names of new members of the Ohio State Medical Association since October 7, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY
Hasler, Norman B., Lima

BUTLER COUNTY
Gerber, David M., Middletown
Tennant, Robert A., Middletown

CUYAHOGA COUNTY
Cross, Frederick S., Cleveland
Csanad, George A., Cleveland
Deshler, Gordon L., Alliance
Hendershot, Edward L., Cleveland
Krueger, Henry G., Cleveland
Paradise, Nicholas, Cleveland
Rodriguez-Trias, Juan, Cleveland
Shapiro, Daniel J., Cleveland
Sherwood, Zalmon O., Geneva

DARKE COUNTY
Boli, V. Ray, Warren
Heise, Jesse L., Pitsburg

FAIRFIELD COUNTY
Boswell, William J., Basil
Essman, Andrew C., Lancaster
Gaines, Kenneth A., Lancaster
Hodsden, Stephen R., Basil
King, Frank C., Millersport
Kraker, Jack L., Lancaster

HAMILTON COUNTY
Abrahamson, Ira A., Jr., Cincinnati
Birmingham, Donald J., Cincinnati
King, Lionel R., Wyoming
McLaurin, Robert L., Cincinnati
Nelson, Robert C., Cincinnati
Nicholas, Louis A., Cincinnati
Richardson, Reubin, Wyoming
Thompson, Carl G., Jr., Wyoming
Watkins, George J., Cincinnati

HANCOCK COUNTY
Fess, Charles D., Findlay
Stealey, Robert L., Arcadia

LAKE COUNTY
Colopy, Robert W., Painesville

LORAIN COUNTY
Kishman, William E., Lorain
Rosenbaum, Herbert, Lorain
Von Kaenel, William E., Vermilion

LUCAS COUNTY
Olms, James S., Toledo

MIAMI COUNTY
Brown, David R., Troy
Hammon, Jerry L., West Milton
South, Dale R., Jr., Troy

RICHLAND COUNTY
Ludwig, James O., Mansfield
Test, Pasquale S., Mansfield
Thompson, Lawrence C., Mansfield

TRUMBULL COUNTY
Birskovich, William F., Warren

TUSCARAWAS COUNTY
Giles, Raymond B., New Philadelphia
Klingler, Raymond A., Baltic
Mastin, Donald W., Dover
Reamy, Harvey Judson, New Philadelphia

WAYNE COUNTY
Cebul, Frank A., Jr., Wooster
Py, Raymond J., Jr., Orrville

WOOD COUNTY
Ebersole, Robert A., Rossford
Kosewick, Sigmund A., Luckey

The Postgraduate School of Medicine of the University of Florida has announced a midwinter seminar in ophthalmology and otolaryngology to be held at the Sans Souci Hotel, Miami Beach, January 18-23.

You and Your Public . . .

County Medical Societies by Use of Local Talent Plus Available Television Motion Pictures Can Bring Messages into Local Homes

AS a joint project of the Department of Public Relations, Bureau of Health Education, and Committee on Medical Motion Pictures, the American Medical Association offers a new service to state and county medical societies—medical television shows on film.

State and county societies can now offer television stations packaged programs for airing on public service time.

Importance of television is emphasized by a statement from National Broadcasting Company Vice-President Edward D. Madden, who says that within three years, 79 per cent of all American homes will be television equipped, and 95 per cent of all homes will be inside the viewing area of television stations.

He estimates that there will be 600 stations in 300 cities by 1956. County medical societies will therefore have increasing opportunities to utilize this service.

THE PERSONAL TOUCH

As pointed out by the American Medical Association a program sponsored by a state or county medical society demonstrates to the people of the community that the doctors are interested in their welfare, and does the job of health education "unequalled through any other means of communication."

"Ideally," the A. M. A. communication stated, "a medical society sponsored television show should be produced 'live,' with extensive visual aids and local physicians. Realizing, however, that many societies cannot devote the time to working up such shows, the A. M. A. is providing filmed TV programs that can be put on the air with a minimum of effort."

These films cannot be shown on local stations unless arrangements are made by the state or county medical society. For that reason, bookings will be accepted only from such societies.

WHERE TO APPLY

To book a television film, write, wire or telephone the TV Film Library, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. The telephone number is WHitehall 4-1500.

The films can be shipped directly to the television station or to the medical society office. There is no charge for this service, however societies are requested to send film prints back prepaid and insured.

Since there are a limited supply of prints available, bookings should be scheduled well in advance. By the same token, films should be returned to the Library just as soon as scheduled showings are completed.

When a television station starts to operate, it often has a number of time segments open. Since "live" telecasts cost money, program managers are especially anxious to fill them with good, high quality film programs. There is an increasing demand for authentic films concerning health.

CONTACT WITH TV STATION

If a television station is scheduled to open in a given area, a representative of the county medical society should talk to the station manager in advance, tell him of the foregoing programs on film, offer cooperation, and arrange for a showing while there is a good choice of time segments.

Most stations will be glad to establish a working relationship with local doctors and to review recommended films. The films offered are of excellent quality and camera work. Subject matter is interesting and informative.

At the present time these films must be limited to public service showings, that is, it is not permitted that commercial sponsors buy time for the films. However, there is no objection to running spot commercials before and after the programs. It is advisable to check such commercials to make sure they are not objectionable and that they do not tie doctors in with the product.

FAMILY APPEAL

In arranging for public service time, it is important to recall that the best segments are when the families are watching, between 5:30 p. m. and 11 p. m., and all day on Sundays. Daytime television shows have a predominantly female audience. Children watch from 3 to 6 p. m. and Saturday afternoons.

When the films are used it is well to consider having a society officer make an opening and closing statement. He can point up the message contained in the program and let viewers know that it was brought to them by the doctors of medicine in their community.

FILMS AVAILABLE

Following are data concerning the films currently available through the TV Film Library. Descriptive literature is available in quantities from the American Medical Association.

"Your Doctor," Louis de Rochemont film now available for the first time on television. Open-

ing with general information about M.D.'s in the United States, "Your Doctor" tells what goes into the training of a physician, then spotlights the career of a general practitioner who serves a rural area of North Carolina. Had wide appeal to audiences who saw it in commercial theatre showings. Running time: 15 minutes.

"Operation Herbert," Fast-moving television play with a humorous touch. Produced under supervision of A.M.A.'s Bureau of Health Education, "Operation Herbert" stars stage, screen and TV actor Jackie Kelk.

Synopsis: Herbert goes to hospital for appendectomy under watchful eye of penny-pinching Aunt Agatha. Becomes interested in his attractive private nurse. To gain nurse's attention and win a point with Aunt Agatha, Herbert demonstrates that it costs less to have an appendectomy now than it did in 1937. Running time: 27 minutes.

"A Citizen Participates," Documentary-type story and underscoring the importance of the individual citizen in solving community problems. Produced by Young America Films, "A Citizen Participates" tells about a town that needs a doctor and how one citizen sparks the campaign to get one. Actually photographed in a small Kansas town, the film also shows how a town interested in getting a physician works to make itself attractive to the prospective doctor and his family. Running time: 28 minutes.

"What to Do," Produced for A.M.A.'s Bureau of Health Education, "What to Do" is a series of six, five-minute films on home medical problems. Nancy Craig, ABC women's commentator, shows "what to do" in using a thermometer, applying artificial respiration, maintaining a medicine chest, and in emergency treatment of colds, abdominal pains and headaches. Use in five-minute spots or as "kick-off" for discussion show. Running time: 5 minutes each.

Industrial Medicine Course Offered in Cincinnati

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships in Industrial Medicine offered to qualified candidates.

The course of instruction consists of a two-year period of intensive training in Industrial Medicine, followed by one year of practical experience in industry. Candidates who complete the course will be awarded the degree of Doctor of Industrial Medicine. Substantial stipends are offered.

A one-year course, without stipend, is also offered to qualified applicants.

Requests for additional information should be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

Do You Know? . . .

Dr. Louis G. Herrmann, associate professor of surgery at the University of Cincinnati College of Medicine, has been named an honorary fellow of the Academy of Surgery of France. Honorary foreign membership is limited to 10 persons.

* * *

Dr. Joseph M. DeNardi, Lorain, and associates are authors of "Berylliosis, Summary and Survey of All Clinical Types Observed in a Twenty-Year Period," which appeared in the July issue of the *A. M. A. Archives of Industrial Hygiene and Occupational Medicine.* Co-authors are Drs. H. S. Van Ordstand, George H. Curtis and John Zielinski, of Cleveland. Reprints are available from the authors.

* * *

Dr. Maurice Levine, director of the University of Cincinnati Department of Psychiatry, has been named to a four-year term on the National Advisory Mental Health Council. The 12-member council advises the U. S. P. S. Surgeon General on the Government's mental health research program.

* * *

Dr. Stanley E. Dorst, dean of the University of Cincinnati College of Medicine, was installed late in October as president of the Association of American Medical Colleges at its 64th annual meeting in Atlantic City.

* * *

During November Mr. Hart F. Page, assistant director of public relations, Ohio State Medical Association, addressed the Northeast District Conference of the Ohio Rural Health Council at Warren November 5 and the Western District at Van Wert November 10. His subject was public participation in public health.

* * *

Dr. Stanley E. Dorst, Dean of the University of Cincinnati College of Medicine, and President of the Association of American Medical Colleges, was scheduled to speak on the subject, "The Heritage of William Osler in 1953," at the University of Buffalo, December 11. A two-day symposium is being held in connection with dedication of a new building for the Medical and Dental Schools.

* * *

In the October issue of the *Ohio Parent Teacher*, the official magazine of the Ohio Congress of Parents and Teachers, appeared an article on social hygiene by Dr. Gordon B. Munson, Dayton, a member of the Ohio State Medical Association Committee on School Health, and an article on rheumatic fever by Dr. Hugh N. Bennett, Youngstown.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement which appears in New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, pp. 171-173, 1953.)

Methantheline Bromide.—*Banthīne Bromide (Searle)*

β-Diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also cause less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastro-intestinal and genito-urinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric, and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degrees may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial dose for adults, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals, and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. Searle & Co.
Powder Banthīne Bromide: 2 cc. ampuls. 50 mg.
Tablets Banthīne Bromide: 50 mg.

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

TIME TO PAY DUES; ANY QUESTIONS?

It's time to pay 1954 local, state and A. M. A. membership dues.

A detailed memorandum on State Association and A. M. A. membership provisions, annual dues, etc., has been sent to the Secretary-Treasurer of each County Medical Society by the Columbus Office.

Those who may have questions regarding their membership status should get in touch with the Secretary-Treasurer of their County Medical Society. He should be able to answer questions after reviewing the Columbus Office memo. If in doubt, the local Secretary-Treasurer should query the Columbus Office which will endeavor to give him the correct information.

Since membership is on a calendar year basis —January 1 to December 31—those who desire to keep their membership up to date should submit dues payments to their local Secretary-Treasurer on or before the end of the year.

SENSATIONAL STORIES UNDERMINING COOPERATION

A good many physicians have been burned up about the sensational article published recently by *Collier's Magazine.* Some believe that there is some way to prevent the publication of articles which leave the public with misleading and false impressions of the medical profession. Obviously, there is no universal solvent for journalistic mudslingers, especially magazines which are fighting for survival. Some physicians have unjustly blamed the A. M. A. for the *Collier's* article and others which have appeared in the past. Here's a statement issued by Dr. George Lull, secretary of the A. M. A., regarding the *Collier's* article which should clarify that criticism:

"After reading the startling and sensational article,, 'Why Some Doctors Should Be In Jail,' in the October 30 issue of *Collier's* magazine, I sent a strongly-worded telegram of protest to Editor Roger Dakin in New York.

"The illustration on the cover page and especially the title gave readers a misleading and distorted picture, and their use, as I told Mr. Dakin, was in "extremely poor taste" on the part of his magazine.

Since the article appeared, many physicians have written letters of protest to me, objecting strongly to the article and especially to the title and promotion used.

"First of all, we did not stimulate the writing of this article. Howard Whitman, the author, was assigned by *Collier's* to write such a story. In gathering his information he visited A. M. A. headquarters in Chicago and requested a statement from the A. M. A. regarding its policy with respect to fee splitting. I gave him a brief statement on how the A. M. A. feels about fee splitting, and it expressed the policy to which the A. M. A. has subscribed for years.

"The way in which the subject was presented left the false impression that I reviewed and approved the article, its title and cover illustration before publication. The fact is that I never saw the article before it was published nor did any of the other medical leaders who were quoted in the story."

It is indeed unfortunate that some magazines and some professional writers have seen fit to engage in yellow journalism on medicine and the activities of the medical profession. The medical profession knows that it has some bad eggs in its ranks. It is just as anxious as anyone else to put an end to their bad practices. It is taking steps to do so.

During recent years, the medical profession has made a real effort to cooperate with representatives of media of public information. Many barriers of the past have been eliminated. The result has been a much better informed public on medical and health subjects.

Most representatives of agencies which dispense public information realize this and appreciate the cooperation they are receiving from the medical profession. Nevertheless, the mavericks in their ranks, like the bad boys in the medical profession, are causing trouble. The few offenders are giving the honest members of their groups a hard time. This is an unfortunate development. It could put a damper on the friendly and cooperative relationships which have been established by a lot of hard work between the two professions in many areas.

In our opinion a return to the old days of secrecy and suspicion because of the actions of a few would be a calamity. There is no universal solvent for bad reporters either, but it's time for the journalism profession and others giving information to the public to do a bit of soul-searching and a little spanking when and where they can.

IT'S THE PEOPLE WHO WILL DECIDE THE ISSUE

A clipping from the editorial columns of the *Washington Post* crossed our desk recently. It carried some pretty meaty advice. Said the *Post*:

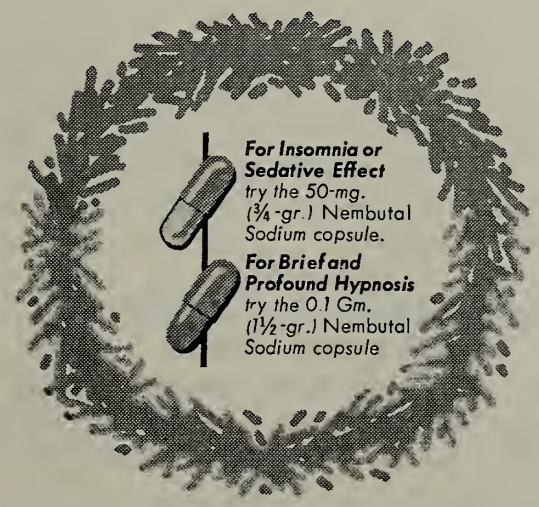
"Dr. Ulrich Redd Bryner, president of the American Academy of General Practice, has given the medical profession some excellent advice. Having twice visited Britain to study the operation of socialized medicine, Dr. Bryner was not favorably impressed by what he saw and heard. But he is clear-sighted enough to see that the



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4. *In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.*

Won't *you* remember—and compare—these advantages the next time, and every time, you write a barbiturate prescription?

Abbott

only reason Parliament created the National Health Services system was that 'the people wanted it.' Overwhelmed by the economic problem of providing adequate medical care for themselves, the people unloaded their burden on the government.

"It would be foolish to suppose that the same forces are not at work in the United States. Every time a family is bankrupted by illness or is forced to pay out all its savings to meet medical bills, sentiment in favor of compulsory health insurance is strengthened. If doctors are going to keep the American public from 'wanting' a government-controlled health system, Dr. Bryner said, they 'must give their patients the best medical care at a price the patients can afford to pay.' In other words, the best guarantee against socialized medicine in the United States lies in a combination of low-cost private insurance plans and restraint and moderation on the part of individual doctors as they fix the rate of their charges."

SOME ENLIGHTENING HOSPITAL FIGURES

Some enlightening figures have just been released by the Ohio Hospital Association on hospital costs during 1952, based on a survey of Ohio hospitals.

Average total per patient day cost of all hospitals in 1952 was $18.60, an increase of 9 per cent over 1951. Total in-patient cost was $17.46, a 9 per cent increase. The breakdown by major departments was: Administrative, $1.87; dietary, $2.90; plant, $3.20; professional $10.63. The increase by departments over 1951 was 9 per cent.

A breakdown of the hospital dollar by departments shows the following: Administrative, $.10; dietary, $.16; plant, $.18; professional, $.56. Ninety-four per cent of the hospital dollar went for in-patient costs.

These are figures which the physician should know and understand, as it is one answer to the patient who fails to realize that there is much more to medical costs than just the bill received from his physician.

HOW DOES YOUR COUNTY MEDICAL SOCIETY STACK UP?

How does your County Medical Society stack up? Is it standing still; progressing or going down hill? Obviously there is not a specific yardstick for measuring any County Society. Nevertheless, a society should take inventory occasionally.

Recently the A. M. A. Council on Medical Service completed one of its bi-annual surveys of County Medical Societies. Pertinent information was secured from 927 County Medical Societies. Following is an abstract of some of the general conclusions revealed by the study and which are offered to all societies as guides for self-analysis and self-improvement.

In regard to meetings, a smaller percentage report monthly or weekly sessions; a smaller percentage report 75-100 per cent attendance. The most popular topic is still the general medical or surgical subject; several societies report disapproval of motion pictures as an attendance aid.

The well-established society committees remain about the same, but there has been a notable increase in grievance committees and in emergency call plans, both of great importance in improving the profession's service to the public. Committees on rehabilitation and on chronic illness and aging are few in number, but, as these were not tabulated in the earlier survey, it is difficult to say whether any increase or decrease has been made in this field.

Reported participation in health councils has decreased; however, this may be due to stricter definition of the term and not representative of an actual decrease.

Most societies still avoid purchase or rental of office space, using hospitals, doctors' offices or restaurants for meetings and official business.

In public education programs, speakers' bureaus remain at about the same level of popularity, with a slight increase in the number of radio programs. The TV program, a new element since the last survey, is not common, but is being tried by a number of societies.

In community programs, a slight decrease was noted in such programs as cancer, tuberculosis, and diabetes countrol, but a slight increase in blood bank support and multiphasic screening. Participation in indigent care remains about the same.

There seems to be a general increase in the number of societies offering group insurance plans, but the relative popularity of the various policies remains about the same, with group health and accident plans most general and group annuities least reported.

The number of executive secretaries in the largest societies seems to have increased, while less are reported from societies with under 300 members.

The dues structure seems to remain much the same, with similar general distribution of societies in each dues bracket. However, there is a slight trend toward higher dues, especially in the larger societies, perhaps in line with increased activity in recent years.

Army Tabs Flu Vaccine For Oversea Troops

American troops in certain overseas commands will be given anti-influenza vaccine this year, according to an announcement by the Department of the Army.

"Experience during the 1952-1953 respiratory disease season, as in other years, demonstrated that effective use of influenza vaccine results only when it is administered prior to the onset of epidemics," said Major General George E. Armstrong, Army Surgeon General.

Local Disaster Relief . . .

Cleveland Academy Describes Elaborate Plan Worked Out in That Area; Physicians and Allied Professions Join Forces for All-Out Program

THE following article, appearing in a recent issue of the *Bulletin of the Cleveland Academy of Medicine*, describes the disaster-relief plans of the Academy's Committee on Civil Defense as currently effective. The plan has taken two-and-one-half years to complete and involves 35,000 county medical personnel and other volunteers. The article was authored by John Pokorny, civil defense director and county coordinator, Cuyahoga County. Dr. A. Macon Leigh is chairman of the Academy's committee.

* * *

The medical plan of the Disaster-Relief Committee of the Academy of Medicine is one of the most comprehensive in the country and certainly goes far beyond most cities in scope and planning.

EXTENSIVE REGISTRATION

During the year 1952, 1,665 physicians representing 95 per cent of the doctors in Cuyahoga County were registered by the Disaster-Relief Committee of the Academy of Medicine for Civil Defense. The remaining 5 per cent were doctors physically disabled or who because of age would be unable to participate in the emergency medical services program. Of this 95 per cent, approximately 60 per cent have now been assigned disaster posts. Two assignments are made—primary and secondary posts.

Approximately 70 osteopathic physicians have been registered through the Cleveland Academy of Osteopathic Medicine and have been classified preparatory to assignment to existing and auxiliary hospitals and first aid teams.

Twenty-five hundred nurses have been registered and classified according to occupational specialty and will be assigned to their disaster posts upon completion of the physicians' assignments. This work has been coordinated by District No. 4, Ohio State Nurses Association.

Eight hundred dentists have been registered through the Cleveland Dental Association and classified according to specialty preparatory to assignment to disaster posts. A training program for dental students in advanced first aid is being conducted at the Dental School of Western Reserve University thus insuring additional first aid personnel on emergency medical teams.

With the cooperation of the Northern Ohio Druggists Association, approximately 400 pharmacists have been registered and their cards prepared for assignment to emergency medical teams. The pharmacists, in addition to serving as supply officers in auxiliary hospitals and aid stations, will be trained in simple laboratory techniques by Dr. Thomas D. Kinney, Chief of Pathology at City Hospital.

EMERGENCY MEDICAL EQUIPMENT

$312,000.00 worth of medical equipment will be stored in Cuyahoga County and the pharmacists have agreed to inventory and inspect it at stated intervals as one of their routine duties. Through the auspices of the Northern Ohio Druggists Association, pharmacies were inventoried for medical equipment and supplies which could be used in disaster.

With the cooperation of the Cuyahoga Funeral Directors Association, 300 morticians and embalmers have been registered, classified and assigned under the mortuary program headed by Dr. Samuel R. Gerber. Each member of this profession has been asked to obtain eight assistants and approximately 309 have been registered. Dr. Gerber has also completed his plan for the identification of the dead and every doctor of medicine and osteopathy has been deputized as a coroner.

A plan for the rotation of perishables has been prepared and is in the final stages of approval before approaching the existing hospitals in Cuyahoga County to rotate these perishables with their normal inventory.

HOSPITALS AND CLINICS

A draft of a hospital manual containing the disaster plans of existing hospitals, surveys of their equipment and capacities, as well as traffic patterns for the reception and evacuation of casualties is completed. A re-survey of new equipment and supplies has just been completed.

Under the leadership of Dr. D. A. Kelly and with the cooperation of the Cleveland Chamber of Commerce, industrial clinics have been surveyed for medical equipment, supplies and personnel. Plans are now being made to integrate these clinics into the emergency medical services program.

The Cleveland Dietetics Association in cooperation with the Disaster Relief Committee has prepared a training and feeding manual for casualties resulting from disaster. Recruitment of trainees and their training will be conducted through the Greater Cleveland Chapter of the American Red Cross.

BLOOD DONOR ROSTER

Under the emergency blood donor program of which Dr. Philip Partington is chairman, 2,000 known "O" type blood donors were contacted by direct mail during the past year. Twenty

per cent of the people contacted have agreed to present themselves to emergency bleeding centers in the event of disaster. Identification cards are being printed and will be sent to those people who have volunteered as emergency blood donors, permitting them to report to the nearest bleeding center.

Preliminary work has been completed on setting up mutual aid agreements for emergency medical services. Dr. C. B. Meuser of Ashland, Ohio, has offered facilities and services of that city for the reception of casualties and evacuees for the Greater Cleveland area.

Pilot studies on a proposed bandage project directed by Dr. D. M. Glover will be conducted in two hospitals. Samples of burn pads which volunteers can assemble have been made and will be used in these two hospitals to determine their efficiency before organizations are requested to make them in quantity.

Of the proposed supply locations for 96 mobile aid teams and 32 auxiliary hospitals in Cuyahoga County, 70 of the former and 29 of the latter have been completely cleared. Twenty-eight of the 48 morgues required have been located and two bleeding centers of the proposed five have been cleared. Apathy among public officials in some of the outlying communities has impeded progress in obtaining all of the locations required.

A revised edition of the uniform treatment manual, "Injuries Resulting from Atomic Explosion" has just been completed.

Physicians and Schools . . .

Ohioans Take Part in National Conference; Need of Definite Local Committee in County Society To Deal With Problems Is Emphasized

NEARLY 200 physicians, public health officials and educators participated in the fourth biennial National Conference on Physicians and Schools sponsored by the American Medical Association at Highland Park, Illinois, September 30 - October 2.

Representatives from 38 states and the District of Columbia participated in discussions which provide the groundwork for further cooperative efforts of the groups represented and parents in the solving of school health problems.

OHIOANS TAKE PART

Addressing the meeting A. M. A. President Edward J. McCormick, Toledo, reported that accidents are the greatest hazard of childhood, killing more than 14,000 children annually. This toll, he said, is more than the combined mortality from the next six main causes of death in children.

Ohioans serving as consultants at the meeting were: Dr. Carl A. Wilzbach, Cincinnati, Committee on School Health, Ohio State Medical Association; Dr. John D. Porterfield, Columbus, Director, and Mr. Sewall O. Milliken, chief of the Division of Health Education, Ohio Department of Health; Professor Delbert Oberteuffer, Ohio State University; William K. Streit, director of Health and Hygiene, Cincinnati Public Schools; and Mr. Hart F. Page, secretary, Committee on School Health, Ohio State Medical Association.

The section studying medical society school health committees released a four and one-half page report on its deliberations, including a statement on organization, functions, methods, and interrelationships of these groups.

The statement reads in part:

"Medical Societies should have active school health committees, clearly identified as such, to coordinate the efforts of the profession in the promotion of the health of the school child."

The functions of such a committee, it was pointed out, are to: (1) Encourage sanction by the medical profession of a sound school health program; (2) to assist in establishing sound policies and procedures and to guide the development of the medical aspects of the program; (3) develop reciprocal relations with the dental society, school system, health department, parent groups and other appropriate organizations, and (4) keep the profession informed as to needs of the program, stimulate its efforts, and report on progress.

"The existence of a medical society school health committee does not relieve the individual physician of the responsibility for active participation in the school health affairs of his community; on the contrary, the committee can increase his effectiveness in this field by providing guidance, direction, advice and encouragement," the report concluded.

The full text of the report can be obtained from the Committee on School Health, Ohio State Medical Association, 79 E. State Street, Columbus 15.

"Following-up" the work of the National Conference, an Ohio Conference on Physicians and Schools is being arranged by the O. S. M. A. Committee on School Health and the State Planning Committee for Health Education. The meeting will be held at Lake Hope Lodge, May 11-13, 1954.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

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Public Health...

Commissioners of Ohio in Columbus Meeting List Recommendations; Local and State Financial Support Is Emphasized by Dr. Porterfield

OHIO health commissioners met in Columbus September 23-25 for their annual three day conference with the Ohio Department of Health.

In his report to the conference Dr. John D. Porterfield, Ohio's health director, said that the principle has been enunciated from authoritative sources that "the Federal Government considered itself to have prime responsibility in the support of medical research, but that the application of benefits of such research to community health was almost completely a state and local financial responsibility."

He pointed out that the state last year experienced a 25 per cent reduction in Federal assistance in health and that the implication is clear that Congress intends to make equally large cuts in subsequent years to the end that within the next several years the only Federal assistance will be in project grants in areas requiring further development.

The Ohio General Assembly, which was in session when the Federal action was taken, increased its support of the state health department from 50 per cent to 70 per cent of the fiscal needs for maintaining the current level of operation.

"In view of the rising salary schedules, this was, indeed a big forward step and one which long needed taking," the director said.

"By and large, states this past year have been inclined to economize in the public health field while, at the same time, continuing to appropriate larger percentages to welfare purposes," the director declared.

"One cannot help but marvel," he said, "at the economic principle which dictates the lapsing of the cost of the ounce of prevention while providing much greater amounts for the pounds of cure."

LOCAL EMPHASIS

Public health is still purchasable, according to Dr. Porterfield, but the price list must be revised. "This is being appreciated in the local communities and the last several years have seen a gratifying response in increased local appropriations for public health purposes."

"Perhaps it is a very wholesome thing," the speaker continued, "that the necessity for financial support is returning to the communities. We in the Ohio Department of Health have anticipated the results of this financial shift. No longer do we buy public health in Ohio by offering money for the establishment of specific services.

"We are trying very hard to assume our proper role—not the controller and director of local health services, but consultants and aids to the community leaders who do provide them."

He also suggested that since the demand for public health is increasing and financial support becoming more difficult the improvement in efficiency of the operations now being provided is indicated.

In order to direct public health efforts more carefully, he said, we must measure their results more accurately. In this connection he announced the development of a four-part schedule by his department for the guidance of local health boards in evaluating community health needs.

RECOMMENDATIONS

The health commissioners approved some thirty recommendations originating in the various committees which met during the conference. Some of these were as follows:

1. The Executive Committee of the conference draft and send to the Ohio State Medical Association a letter asking for cooperation of the Association's members who are board of health members, in order that better attendance of doctors at board sessions may result.

2. The Ohio Department of Health and the Ohio Public Health Association be urged to support the introduction of a new bill for licensing nursing homes by the Ohio Department of Health instead of the Ohio Department of Public Welfare.

3. The Ohio Department of Health foster legislation making it possible for forceful isolation and treatment of recalcitrant active tuberculous patients in a state-operated central facility.

4. The Ohio Department prepare and distribute to all local departments methods and procedures for the investigation and control of infectious diarrhea in children's hospitals and nurseries of general hospitals, as well as of food borne gastrointestinal diseases.

5. The Ohio Department provide an educational program for local health department personnel for better utilization of the reports by physicians of communicable diseases.

6. The local health departments adopt as standard procedure a very careful investigation of each reported case of diphtheria and that standardized immunization procedures be formulated by the Ohio Department and sent to all health jurisdictions.

7. The State Department take the necessary steps to promote the recruitment and training



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of health education personnel to meet the needs of local departments and communities.

8. Safety education be incorporated in the over-all local health department programs.

9. The responsibility of the local health departments in relation to the civil defense program be clarified.

10. There be a review of the dog laws of the state with a view to recommending changes and provide for most efficient enforcement with the possible inclusion of requirements for the immunization of dogs against rabies; and that recommended procedures and programs for such immunizations be worked out by the Ohio Department in cooperation with the Ohio State Veterinary Medical Association.

V. A. To Ask Financial Data In Non-Service Connected Cases

Under a new policy, Veterans Administration from now on will ask additional information from a veteran applying for hospitalization of a non-service connected condition. Previously, the veteran had only to answer the question: "Are you financially able to pay the necessary expense of hospitalization or domiciliary care?" If the answer was "no," the veteran was eligible. Now the veteran will be required to answer the following additional questions:

1. What is the current value of your property, real and personal?

2. What is the current amount of your ready assets in the form of cash, bank deposits, savings bonds, etc.?

3. If you own real property, what is the approximate amount of the unpaid mortgage or other indebtedness?

4. What are your average monthly expenditures, including mortgage payments and all other personal expenses, including your expenses for dependents?

5. What was your average monthly income for the last six months, from all sources?

However, the V. A. states: "This addendum may be used in no way whatever to deny hospitalization to a veteran, as the law specifically provides that 'the statement under oath of the applicant . . . shall be accepted as sufficient evidence of inability to defray necessary expenses.' (It) is designed to protect applicants for hospitalization, and veterans generally, from charges of 'chiseling' on the government."

"A Job For Everyone" is the title of an article written by Mr. Hart F. Page, assistant director of public relations of the Ohio State Medical Association, and appearing in the November issue of the *Ohio Parent Teacher*. Mr. Page described the efforts of Ohio physicians in attempting to stem the increasing incidence of accidents to children.

What To Write for

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Scientific Publications, 1953. Catalogue of scientific and technical literature published for physicians by the A. M. A. Available free from the Bureau of Health Education, American Medical Association, 535 North Dearborn St., Chicago 10.

Do You Need a Will? Answers to common questions about the importance of making a will, free from the Ohio State Bar Association, State House Annex, Columbus 15, Ohio.

Safety for the Household. Reference book on the elimination of common household hazards. 190 pages; price, 75 cents. Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Get Your Money's Worth When Buying Termite Control. Four pages. Price, five cents, from Dallas Better Business Bureau, 2022 Bryan Street, Dallas, Texas.

Under the Dome. Describes how the House and Senate work, how a bill is presented, and how a bill becomes law. Price 15 cents, from Legislative Department, Chamber of Commerce of the U. S., 1615 H. St., N. W., Washington 6, D. C.

The Medical Profession's Role in School Health Programs. (School Health Guide No. 1) Published by, and available free from the Committee on School Health, Ohio State Medical Association, 79 E. State Street, Columbus 15.

Health Exhibits. Lists health exhibits available to county medical societies for fairs, expositions, etc. Available free from Bureau of Exhibits, American Medical Association, 535 North Dearborn St., Chicago 10.

Moving to Another State? Facts you should know if you plan to move from one state to another. Describes services movers offer, explains rates, and lists 16 things you can do to help make your move easier. 11 pages. Free from Movers' Conference of America, 16th and P Streets N. W., Washington 6, D. C.

Winning Ways With Patients. Tips for the physician's secretary, receptionist or office girl, in practicing good public and patient relations. Available free from American Medical Association, 535 North Dearborn St., Chicago 10.

Your Federal Income Tax. Authentic information on how to fill out your income tax forms for the current year; price 25 cents; Superintendent of Documents, Government Printing Office, Washington 25, D. C.

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UROLOGICAL PATHOLOGY

This course is designed to familiarize the students with the newer laboratory tests used in clinical biochemistry and their interpretation; normal and pathological physiology of the urinary tract with instruction in technic of urinalysis, kidney function tests, bacteriology of urine and the various secretions of the genitourinary tract; chemical examination of blood in its relation to diagnosis of genito-urinary diseases; dark field illumination for Treponema (spirocheta) pallidum and the Wassermann, Kahn and other tests in relation to syphilis. Didactic lectures and individual instructions are given in normal histology, gross and microscopic pathology of the genito-urinary diseases, including congenital abnormalities, inflammatory, degenerative, traumatic and neoplastic lesions.

RADIOLOGY

A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both X-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, pre-renal insufflation and myelography. Discussions covering roentgen departmental management are also included; attendance at departmental and general conferences.

COURSE FOR GENERAL PRACTITIONERS

Intensive full time instruction covering these subjects which are of particular interest to the physician in general practice. Fundamentals of the various medical and surgical specialties designed as a practical review of established procedures and recent advances in medicine and surgery. Subjects related to general medicine are covered and the surgical departments participate in giving fundamental instruction in their specialties. Pathology and radiology are included. The class is expected to attend departmental and general conferences.

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Industrial Commission . . .

State Agency in 1952 Paid Out All-Time High of $6,888,162 For Medical Services, Representing 334,344 Claims Filed in Year

THE Industrial Commission of Ohio reached a new peak in the number of claims filed and in the amount paid out for medical services to injured Ohio Workmen during 1952, according to information furnished by the Actuarial Section of the Commission. The amount paid was $6,888,162, which included a relatively small sum for dental services.

Other expenditures during the year, exclusive of compensation payments included: $6,055,942 for hospital care and nursing; $269,043 for funeral expenses, and $218,055 for miscellaneous costs. With disbursements for medical services added, the total is $13,431,204.

These amounts include payments covering treatment of injured private and public employees, as well as similar costs for occupational disease claims.

Comparative figures for 1951 were as follows: $5,919,623 for medical service; $4,843,228 for hospital care and nursing; $212,193 for funeral expenses, and $197,670 for miscellaneous costs —a total of $11,172,716.

The number of claims filed during 1952 was 334,344 or 3 per cent more than in 1951. This was an all-time high number of claims for the Commission. The previous peak year was 1943 when the number of claims reached 331,072, of which 81 per cent were "medical only" claims. The average number of claims filed each working day in 1952 was 1,337.

"Medical-only" claims, involving payment for physicians' services, but with no compensation to the claimant for loss of time, numbered 275,-108 in 1952, or 82 per cent of all claims filed. The average amount paid out per "medical-only" claim increased from $14.50 in 1951 to $14.71 in 1952.

Table 1 is a financial statement of the Ohio Insurance Fund.

Table 2 gives 1952 awards that have been made for active claims according to the year of injury, and having injury dates which in some instances reach back to the beginning of the fund.

TABLE 1

OHIO STATE INSURANCE FUND
(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION
As of December 31, 1952

ASSETS

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	$ 2,379,917.67	$ 103,933.36	$ 12,868.37	$ 15,915.55	$ 2,512,634.95
Bonds	151,577,779.44	6,619,328.75	819,786.65	1,013,295.16	160,030,190.00
Premiums Due	22,509,874.50	2,408,378.75	3,511.29	--	24,921,764.54
Accrued Interest	702,395.79	30,673.29	3,798.81	4,695.50	741,563.39
Total Assets	$177,169,967.40	$9,162,314.15	$839,965.12	$1,033,906.21	$188,206,152.88

LIABILITIES

Reserve for Medical & Compensation Claims	$132,656,637.00	$8,953,604.00	$105,240.00	$ ----	$141,715,841.00
Reserve for Allocated Surplus Adjustment	--	2,006.61	----	----	2,006.61
Balance of Allocation for Rehabilitation Center	209,610.00	15,390.00	----	----	225,000.00
Outstanding Warrants	2,560,093.37	189,738.39	359.21	12,069.01	2,762,259.98
Advance Premium Deposits	23,036,894.63	----	----	--	23,036,894.63
Fund	----	----	----	1,021,837.20	1,021,837.20
Reserve for Contingencies and Surplus	18,706,732.40	1,575.15	734,365.91	----	19,442,673.46
Total Liabilities	$177,169,967.40	$9,162,314.15	$839,965.12	$1,033,906.21	$188,206,152.88

TABLE 2—PRIVATE FUND

1952 Medical, Hospital, Etc., Awards Distributed to Year of Injury Occurrence
(Accident and Occupational Disease Combined)

Year of Accident or Disease	Medical Hospital, Etc.	1952 Per Cent	1951 Per Cent
1952	$ 5,860,890	47	47
1951	4,449,994	36	28
1950	667,752	5	7
1949	302,557	2	4
1948	189,292	2	3
1947	411,677	3	2
1946	170,295	1	3
1945	123,711	1	1
1944	118,912	1	1
1943	89,102	1	1
1912 - 1942	138,054	1	3
	$12,522,236	100	100

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states. Intended city of residence stated in application and medical school of graduation are given.

October 6—Abdel R. Abla, Cleveland, American University of Beirut, Lebanon; Jarrell W. Benson, Cleveland, Johns Hopkins; Michael R. Billinson, Cincinnati, State University of New York;

Richard H. Champion, Akron, St. Louis University; Frederick L. Clement, Cleveland, University of Toronto, Canada; Alfred R. Conti, Bellaire, University of Pittsburgh; William W. Davis, Columbus, Vanderbilt; Raymond J. Dittrich, Toledo, University of Minnesota; Glenn B. Doan, Cincinnati, University of Buffalo;

Lelabelle C. Freeman, Cleveland, Howard University; Robert L. Friedman, Columbus, University of Edinburgh; Robert K. Funkhouser, Cleveland, Harvard University; Angelo W. Geordan, Youngstown, Loyola University; Chandler D. Gibbs, Lima, Meharry Medical College;

George A. Hays, Columbus, University of Arkansas; Richard M. Hannah, Akron, Yale; Alfred E. Hollenberg, Hollansburg, Indiana University; Thomas H. Hoover, North Canton, Cornell;

William J. Johnson, Bellaire, Yale; Jay M. King, Marion, Indiana University; Charlotte C. Levine, Martins Ferry, Johns Hopkins;

John K. MacLeod, Cincinnati, Tufts College Medical School; Photius Mamos, Dayton, University of Vermont; Alfred M. MarCia, Parma, University of Illinois; Ronald W. Martz, Columbus, Temple University; Edward C. Matthews, Cincinnati, McGill University, Montreal, Canada;

John A. Norman, Akron, Northwestern; John E. Osborne, Miamisburg, University of Virginia; Raphael O. Patt, Cleveland, University of Kaunas, Lithuania; Logan Robertson, Hamilton, University of Cincinnati; Bruce F. Rothmann, Cuyahoga Falls, New York University; Roy C. Rounds, Dayton, University of Wisconsin;

George A. Segal, Dayton, University of Vermont; Earl L. Shook, Jr., Barberton, New York Medical College; Edward C. Spitze, Jr., Columbus, Washington University; Ruth Stekert, Canton, Temple University; Earl W. Sutherland, Jr., Cleveland, Washington University; Robert F. Swanson, Cleveland, Northwestern;

John F. Thompson, Canton, Jefferson Medical College; Frank C. Vogt, Marion, Cornell; Ralph J. P. Wedgwood, Cleveland, Harvard Medical College.

Dr. R. W. Kissane, Columbus, was principal speaker at a recent course in Charleston, W. Va., on the subject, "Recent Advances in Cardiac Therapy."

Kefauver New Medical Chief of Ohio Industrial Commission; Andre Takes Post at New U. S. Atomic Plant

Dr. Addison L. Kefauver took over the position of medical director of the Ohio Industrial Commission on November 16, succeeding Dr. Robert M. Andre, who had held that post since 1942.

Dr. Andre tendered his resignation in order to take the position of medical director of the atomic plant in Pike County which is being operated for the United States Government by the Goodyear Tire and Rubber Company.

Dr. Kefauver had been assistant medical director of the Ohio Industrial Commission since 1942. Prior to that he was a member of the medical staff of the Commission, serving for a number of years in the Commission's branch office at Cleveland. Prior to becoming medical director of the Commission in 1942, Dr. Andre engaged in private practice in Waverly.

The Commission has named Dr. Raymond B. Hudson as assistant medical director. Dr. Hudson is a long-time employee of the Medical Section and has been serving as chief medical examiner.

School Health, Accident Prevention Promoted by Association

During October and November the School Health Committee and Department of Public Relations of the Ohio State Medical Association presented exhibits emphasizing childhood accident prevention at the annual meetings of three statewide organizations.

These were the Ohio Congress of Parents and Teachers, meeting in Cincinnati, October 5, 6, and 7; Ohio Society for Crippled Children, Columbus, October 17 and 18; and the Ohio Welfare Conference, Columbus, November 16, 17, 18 and 19.

Distributed in connection with the exhibits were copies of the booklet, "What Should I Do," which provides suggestions on preventing childhood accidents, first aid instructions, immunization records and a telephone list. This booklet is published by the Cincinnati Pediatric Society, The Children's Hospital of Cincinnati, and the Greater Cincinnati Safety Council.

Also given out were copies of School Health Guide No. 2, giving information on preparing for school emergencies of sickness or accident, and School Health Guide number 3, *Suggested Standing Orders for School Medical Emergency Procedure.* Both are publications of the O. S. M. A. Committee on School Health.

Exhibits were obtained from the Bureau of Exhibits of the American Medical Association.

Conclusive evidence

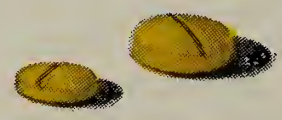
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Nitrofurantoin is useful by oral administration for the treatment of bacterial infections of the urinary tract and is indicated in pyelonephritis, pyelitis, and cystitis caused by bacteria sensitive to the drug. It is not intended to replace surgery when mechanical obstruction or stasis is present. Following oral administration, approximately 40% is excreted unchanged in the urine. The remainder is apparently catabolized by various body tissues into inactive, brownish compounds that may tint the urine. Only negligible amounts of the drug are recovered from the feces. Urinary excretion is sufficiently rapid to require administration of the drug at four to six hour intervals to maintain antibacterial concentration. The low oral dosage necessary to maintain an effective urinary concentration is not associated with detectable blood levels. The high solubility of nitrofurantoin, even in acid urine, and the low dosage required diminish the likelihood of crystalluria.

Nitrofurantoin has a low toxicity. With oral administration it occasionally produces nausea and emesis; however, these reactions may be obviated by slight reduction in dosage. An occasional case of sensitization has been noted, consisting of a diffuse erythematous maculopapular eruption of the skin. This has been readily controlled by discontinuing administration of the drug. Animal studies, using large doses administered over a prolonged period, have revealed a decrease in the maturation of spermatozoa, but this effect is reversible following discontinuance of the drug. Until more is known concerning its long-term effects, blood cell studies should be made during therapy. Frequent or prolonged treatment is not advised until the drug has received more widespread study. It is otherwise contraindicated in the presence of anuria, oliguria, or severe renal damage.

Dosage.—Nitrofurantoin is administered orally in an average total daily dosage of 5 to 8 mg. per kilogram (2.2 to 3.6 mg. per pound) of body weight. One-fourth of this amount is administered four times daily—with each meal and with food at bedtime to prevent or minimize nausea. For refractory infections such as Proteus and Pseudomonas species, total daily dosage may be increased to a maximum of 10 mg. per kilogram (4.5 mg. per pound) of body weight. If nausea is severe, the dosage may be reduced. Medication should be continued for at least three days after sterility of the urine is achieved."

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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

It is predicted that increased attention will soon be given to the physiological fitness of airline pilots. The Aero Medical Association is one group working for the establishment of a commission which would tackle this problem.

* * *

Newest Veterans Administration mental hospital of 1,000 beds was dedicated last month in Brockton, Mass.

* * *

Food and Drug Administration has seized 50 shipments of Tryptacin on grounds that its advertised claims as an "ulcer cure" are at odds with legend on the label.

* * *

Social Security Committee of American Federation of Labor, meeting in Washington recently, again urged "a sound and democratic system of national health insurance."

* * *

Annual Conference of State and Territorial Health Officers, meeting in Washington during November, took following action: Opposed reduction of Federal grants to states pending findings of Manion Commission; apprised Federal and state governments of necessity of increased funds for civil defense operations; urged that water pollution be attacked with renewed vigor; asked $150 million annually as Federal contribution to Hill-Burton hospital expansion.

* * *

For fifth consecutive year, Atomic Energy Commission will offer fellowships in industrial medicine in 1954-1955. Eight places will be filled with stipends ranging from $3,600 upward.

* * *

Food and Drug Administration has won latest round in battle against Hoxsey Cancer Clinic. Fifth Circuit Court of Appeals has ordered Judge William H. Atwell to place an injunction against Hoxsey medicine shipments that will be without favoring loopholes.

* * *

At recent meeting of Association of American Medical Colleges increasing resistance to proposed Federal financial aid to medical schools was noticeable. On basis of a mail ballot survey, only 60 per cent of the deans still advocate Federal aid, whereas in 1949 about nine out of 10 wanted the subsidies. "A. M. A. opposition to Federal aid; money raising drive of National Fund for Medical Education, and increasing skepticism of year-to-year fluctuations of Congressional appropriations are chief reasons . . . ," one reporter ventured.

* * *

Curtis subcommittee resumed hearings last month on social security coverage . . . had been recessed since last July. Status of professional people and other self-employed will no doubt be discussed.

* * *

At a three-day symposium on antibiotics held in Washington last month, much interest was focused on one of the newer drugs known as tetracycline. "Stern warning" was sounded against overuse of penicillin, with consequent dangers of sensitization. Several speakers pointed out that sulfonomides still maintain a rightful place in chemotherapy despite phenomenal rise of antibiotics.

* * *

"Tums" will stop advertising claims relating to its efficacy against gastric acidity, according to stipulation entered into with Federal Trade Commission.

* * *

Senator William Langer (R., N. D.), chairman of Senate Judiciary Committee, has told one Washington reporter that he intends to hold additional hearings soon on "cold-shouldering of chiropractic by Federal medical services."

* * *

Veterans Administration and Public Health Service will collaborate in a study which, it is hoped, will settle question of relationship between tobacco consumption and incidence of lung cancer. Some 350,000 veterans, majority of them aged 55 and up, will receive a questionnaire requesting information on smoking habits. Return of a quarter of a million forms is anticipated. Mortality expectancy of the group chosen is about 5,000 a year, and some answers should emerge within three or four years it is said.

* * *

The U. S. Supreme Court has under advisement the question of whether the Federal lobbying act is constitutional. There is no indication as to when the court will make a decision.

* * *

John W. Tramburg, a 40-year-old Wisconsin Republican, is the new administrator of the Federal Social Security Administration. He is

chairman of the Council of State Public Assistance and Welfare Administrators and since 1950 has been director of Wisconsin Department of Public Welfare. The position he fills has been vacant since the resignation earlier this year of Arthur J. Altmeyer.

* * *

Dudley A. White, publisher of newspapers in Sandusky and Norwalk, Ohio, has been appointed executive director of Manion Commission (Commission on Intergovernmental Relations for the Study of Federal-State Relations). Commission is headed by Clarence E. Manion, former Dean of College of Law, Notre Dame University. Two working committees have been named to the Commission, a projects and organization committee, and another to study principles and historical development of the Federal government.

* * *

Dr. Frank Brown Berry, New York surgeon, will succeed Dr. Melvin A. Casberg as Assistant Secretary of Defense for health and medical affairs. Dr. Berry is professor of clinical surgery at Columbia University Medical School. Dr. Casberg is returning to private practice in Solvang, California.

Medical task force of Hoover Commission on government reorganization will meet in Washington every two weeks until survey of Federal medical programs has been completed.

* * *

After she had refused to accept transfer to another assignment, Miss Jane Hoey was officially discharged from her position as director of the Bureau of Public Assistance in the Department of Health, Education and Welfare. Contrary to Miss Hoey's claims, the Civil Service Commission ruled that her job was in the policy-making bracket, and she was therefore forced to give way to an administration appointee.

* * *

The Department of Health, Education, and Welfare is closing its Cleveland regional office "as part of an overall plan to achieve more efficiency and economy." This change places Ohio and Michigan under the Chicago office.

* * *

Public Health Service has announced that a pure compound that temporarily lowers blood pressure in animals has been isolated from rhododendron leaves by scientists of the National Heart Institute. Called dromedotoxin, it is said to be chemically pure, but its structure is a mystery.

In Memoriam . . .

Robert F. Bell, M. D., formerly of Cleveland; University of Buffalo School of Medicine, 1945; aged 35; died October 28 in Chicago. Dr. Bell did medical service work under the U. S. Government in the South and was a medical missionary for the Gospel Church of Cleveland in Ethiopia. He is survived by his widow, a son, his parents and a brother.

Hugh Alan Briscoe, M. D., Akron; University of Cincinnati College of Medicine, 1918; aged 61; died June 19; member of the Ohio State Medical Association; member of the American Medical Association.

Daniel J. Bryant, M. D., Astatula, Fla.; Cleveland Medical College, Homeopathic, 1897; aged 80; died September 11. A practicing physician in Cleveland for about 45 years, Dr. Bryant retired and moved to Florida three years ago. He was a member of the Cleveland Homeopathic Society.

Matthew Wray Davies, M. D., Delaware; Ohio State University College of Medicine, 1910; aged 67; died October 17; member of the Ohio State Medical Association; member of the American Medical Association; former delegate of the Delaware County Medical Society to the State Association and active on numerous local committees. Dr. Davies practiced for 43 years in Delaware. He was Delaware County coroner continuously from 1938 and for several terms prior to that. Active in local affairs of the community, he was a member of the Methodist Church, Nu Sigma Nu, and several Masonic bodies. Surviving are his widow and a daughter.

William Davis, M. D., Akron; Ohio State University College of Medicine, 1934; aged 46; died May 8; member of the Ohio State Medical Association; member of the American Medical Association.

Vanderveer T. Carr, M. D., Jamestown, N. Y.; Hahnemann Medical College and Hospital, Chicago, 1907; aged 71; died October 21. Dr. Carr formerly practiced in Urichsville and in Tiffin.

Harold E. Fruth, M. D., Columbus; Chicago College of Medicine and Surgery, 1915; aged 60; died October 12; member of the Ohio State Medical Association, through 1951. Dr. Fruth practiced in Fostoria from 1920 until 1951 when he moved to Columbus to become a physician for the Pennsylvania Railroad. A veteran of World War I, he was a member of the American Legion. Other affiliations include the American Association of Railway Surgeons, the Masonic Lodge, the Elks Lodge and the Episcopal Church. A son and a daughter survive.

Charles F. Good, M. D., Cleveland; Western Reserve University School of Medicine, 1927; aged

52; died October 16; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Pediatrics; active on numerous County Society committees. Dr. Good was directing supervisor of the Medical Department in the Cleveland Public Schools since January of 1942. During the War he was a lieutenant colonel in the Army Medical Corps and served in England. For a number of years prior to the war, he was associated with the Babies' and Children's Hospital of Western Reserve University. In 1948 he was appointed on the national advisory committee dealing with maternal and child health and crippled children's services for the Social Security Administration. Surviving are his widow, a son and a daughter.

Homer John Hartzell, M. D., Cleveland; Cleveland College of Physicians and Surgeons, Cleveland, 1902; aged 80; died November 1; member of the Ohio State Medical Association and the American Medical Association through 1952; member of the Cleveland Ophthalmological Club. After receiving his medical degree, Dr. Hartzell was resident physician at Cleveland General Hospital and Cleveland State Hospital and served in a hospital for contagious diseases during a smallpox epidemic. He held teaching appointments in the Departments of Chemistry and Pharmacolgy of Western Reserve during the period 1910 to 1916, and pursued an active general practice during that period. In 1915 he took graduate training at Harvard and subsequently confined his practice to his specialty. He taught ophthalmology at Western Reserve from 1919 through 1935 and was consultant in eye diseases to the Cleveland Public Schools. In 1952 he was honored by the Cleveland Academy with the 50-Year Pin and Certificate of the State Association. Surviving are his widow, a daughter and a son, Dr. Homer C. Hartzell, Brecksville.

Hubert C. King, M. D., Lakewood; Western Reserve University College of Medicine, 1914; aged 64; died October 17; member of the Ohio State Medical Association through 1952; president of the Cleveland Academy of Medicine in 1939 and member of the Board of Directors, 1939-1940; delegate to the State Association in 1933; and active on several local committees. Dr. King was a practicing physician in Cleveland for about 40 years. For 15 years he was director of medicine at Fairview Park Hospital and in recent years was director emeritus. Survivors include his widow, a son and two daughters.

Charles A. Langdale, M. D., Coral Gables, Fla.; Medical College of Ohio, Cincinnati, 1903; aged 79; died October 26; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Langdale was a practicing physician in Cincinnati before his retirement in 1946 when he moved to Florida. He had served on the staffs of General, Good Samaritan and Children's Hospitals and was a charter member of the American College of Surgeons. His widow survives.

Bernard Levenberg, M. D., Cleveland; University of Alabama School of Medicine, 1896; aged 82; died November 2; member of the Ohio State Medical Association through 1947. After receiving his medical degree in Alabama, Dr. Levenberg practiced there for a short time before moving to Cleveland about the turn of the century. He also took postgraduate work in Vienna. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. His practice included work as head of the staff of the Orthodox Old Home for many years. His widow and a daughter survive.

Alexander William Lueke, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1897; aged 79; died October 12; former member of the Ohio State Medical Association, last in 1919. An active practitioner for many years, Dr. Lueke from about 1919 had devoted much of his time to two industrial firms in which he held directorships. He retired from active practice in 1935. His widow and two sisters survive.

James F. O'Hara, Jr., M. D., Canton; University of Maryland School of Medicine, 1940; aged 38; died October 11; member of the Ohio State Medical Association; member of the American Medical Association. Dr. O'Hara had been a practicing physician in Canton since 1942, when he completed internship training at Mercy Hospital. In addition to his interest in professional associations, he was active in several local organizations. He was a member of the Catholic Church, the Knights of Columbus, the Order of Foresters and the Elks Lodge. The son of Dr. James F. O'Hara, Sr., he is survived also by his widow, five sons, three brothers and three sisters.

Charles R. Price, M. D., Dayton; Ohio State University College of Medicine, 1930; aged 50; died October 30; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Price had been a practicing physician for a number of years in Dayton. He was a member of Alpha Phi Alpha. His widow and a brother survive.

William P. Prowdley, M.D., Cleveland; Michigan College of Medicine and Surgery, Detroit, 1899; aged 76; died October 27. Dr. Prowdley had practiced for many years in Madison, Lake County. He had been virtually retired after moving to Cleveland. His widow survives.

George R. Roessly, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1904; aged 80; died November 8; member of the Ohio State Medical Association; member of the American Medical

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Association. Dr. Roessly practiced for 49 years in Cincinnati. Survivors include a daughter, a sister and two brothers.

Bert Andrew Rose, M. D., Dayton; Howard University College of Medicine, 1912; aged 68; died October 21; member of the Ohio State Medical Association. Dr. Rose practiced medicine in Dayton for more than 30 years. In addition to his practice, he was active in many fraternal and civic enterprises. He had been given an honorary degree from Wilberforce University for his contributions in lectures there. He was past national president of Alpha Phi and grand secretary of Sigma Pi Phi. He was active in establishment of a Y. M. C. A. branch on the west side of Dayton, and was active on the original staffs of the Linden Center and the St. Clair Public Health Center. His widow survives.

Dempsey O. Sheppard, M. D., Barnesville; Starling Medical College, Columbus, 1897; aged 86; died September 30; member of the Ohio State Medical Association; member of the American Medical Association; active on several committees of the Belmont County Medical Society. Dr. Sheppard served his entire professional career in Barnesville and vicinity with the exception of time served in the Medical Corps during World War I. He had been honored with the 50-Year Pin of the Ohio State Medical Association. Active in all phases of community life, Dr. Sheppard was member of the Methodist Church and the Masonic Lodge. His hobby as a historian culminated in publication of a 375-page "History of Barnesville." Surviving are his widow, four daughters, a sister and a brother.

Jacob Siebert, M. D., Cleveland; University of Wooster, Medical Department; Cleveland; 1907; aged 66; died October 27; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Siebert practiced for about 45 years in Cleveland. Affiliations included memberships in several Masonic bodies including the Consistory and Shrine. Survivors include his widow, a son, a step-son, three daughters and three sisters.

Frances Roush Sutter, M. D., Shelby; Laura Memorial Woman's Medical College, Cincinnati, 1896; aged 82; died November 1. A practicing physician for many years, Dr. Sutter was a member of the Presbyterian Church and a past matron of the Order of Eastern Star. She was the widow of the late John C. Sutter.

Llewelyn Ivor Thomas, M. D., Akron; Jefferson Medical College, 1912; aged 66; died November 10; member of the Ohio State Medical Association; member of the American Medical Association. A practicing physician in Akron for many years, Dr. Thomas was associated with the Akron Health Department since 1938 and was a resident physician at the Akron Clinic. A veteran of World War I during which he served with an ambulance unit in France, he was a member of the American Legion. Later he was commissioned a captain in the Army Medical Corps. Survivors include his widow and two brothers.

Abraham Lincoln Tinstman, M. D., Cleveland; University of Pittsburgh School of Medicine, 1896; aged 93; died November 2. Dr. Tinstman had been a practicing physician in Cleveland since before the turn of the century. His widow and a brother survive.

Formation of American Foundation for Allergic Diseases Announced

The newly formed American Foundation for Allergic Diseases is now in operation with headquarters at 55 Lexington Ave., New York 17, according to an announcement from Dr. Horace S. Baldwin, of New York, its president.

Dr. Jonathan Forman, Columbus, Editor of *The Journal.* has been named a member of the board of trustees, which is composed of 20 physicians from various parts of the country.

In his announcement Dr. Baldwin said that in 1952 a fact-finding survey was undertaken by members of the executive committee of the American Academy of Allergy and the board of regents of the American College of Allergists who studied the problems and objectives to be gained from joint participation, and to determine the precise areas of need for such a foundation.

The joint group, he said, set forth basic principles on which the Foundation would operate, outlined a program of activities, and defined joint supervision and sponsorship by the Academy and the College. With the findings of the survey, the two groups organized the Foundation, a national, voluntarily supported, non-profit organization.

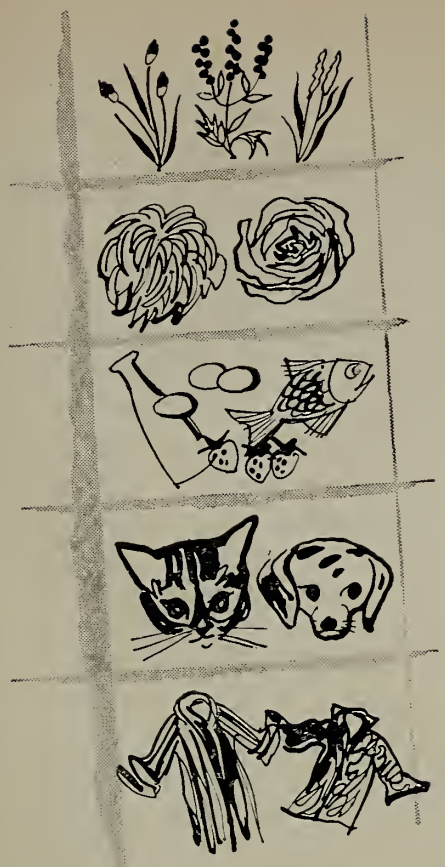
The purpose of the Foundation is to fulfill "the need for some central organization to stimulate and coordinate activity in the allergy field."

American College of Surgeons To Hold Regional Meetings

The medical profession at large is invited to attend any of six sectional meetings of the American College of Surgeons to be held between February 1 and May 19. Locations and dates have been announced as follows:

Charlotte, N. C., February 1-3.
Reno, Nevada, February 25-26.
Omaha, Nebraska, March 1-4.
French Lick Springs, Ind., March 15-17.
Montreal, Quebec, March 31-April 2.
London, England, May 17-18.

Inquiries about details may be addressed to Dr. H. Prather Saunders, associate director, American College of Surgeons, 40 E. Erie St., Chicago 11.



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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

HAMILTON

The Academy of Medicine of Cincinnati held a joint meeting with the Cancer Council on November 10 at which Dr. Earl D. Osborne, professor of dermatology and syphilology, University of Buffalo School of Medicine, spoke on the subject, "Treatment of Skin Cancers."

At the November 24 meeting, Dr. John C. Burch, professor of obstetrics and gynecology, Vanderbilt School of Medicine, spoke on the subject, "The Management of Leukorrhea."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL

DARKE

The subject, "Pruritus Ani," was discussed by Dr. Sidney M. Copland, of Dayton, at the November 17 meeting of the Darke County Medical Society in Greenville.

GREENE

Dr. John J. Shay, Dayton, spoke on the subject, "Dermatological Allergies," at the November 12 meeting of the Greene County Medical Society in the Greene Memorial Hospital, Xenia.

MIAMI

Speaker for the November 6 meeting of the Miami County Medical Society was Dr. Harry Nieman, Dayton, who discussed common skin conditions. The meeting was held in the Nurses' Home of Piqua Memorial Hospital.

MONTGOMERY

Dr. R. W. TeLinde, professor of gynecology, Johns Hopkins University, and president of the American Gynecological Society, was guest speaker at the November 6 meeting of the Montgomery County Medical Society in Dayton.

In a clinical conference at the Van Cleve Hotel, sponsored by the Dayton Surgical Society, the following cases were discussed: Urinary incontinence in the female; principles in reconstructive surgery; selection of operations; endocrinology; and carcinoma of the uterus.

A cocktail hour, during which Dr. Robert C. Austin, president of the local Society was host, was held at the Van Cleve.

The banquet at the same hotel was sponsored by the Dayton Obstetrical and Gynecological Society. Dr. TeLinde spoke on the subject, "Endometriosis."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

CRAWFORD

"You and Your Public" was the topic discussed by George H. Saville, Director of Public Relations, Ohio State Medical Association, at a meeting of the Crawford County Medical Society, Thursday evening, Oct. 29, at the Galion City Hospital.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

PUTNAM

The monthly meeting of the Putnam County Medical Society was held at the Hotel Dumont, Ottawa, on November 4. Colored films from the American Cancer Society were shown, outlining latest diagnostic methods, including biopsy procedures. A nominating committee for 1954 officers was appointed by the President, Dr. Joseph J. McHugh, Ottawa.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

The 16th annual Lower Lecture was given at the Medical Library Auditorium on November 20. Speaker for the occasion was Dr. John Jones, professor of surgery, University of Southern California, who spoke on "Present Status of the Surgical Treatment of Congenital Lesions of the Heart and Great Vessels."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Dr. Melvin Casberg, Assistant Secretary of Defense for Health and Medical Affairs, was guest speaker at first fall meeting of the Mahoning County Medical Society. More than 175 members attended. Dr. Casberg described medical policy in the military forces.

STARK

Four doctors were honored with the 50-Year Award of the Ohio State Medical Association at the November 12 meeting of the Stark County Medical Society in Canton. They are Dr. Charles E. Abell, Dr. John E. Shorb, Dr. L. D. Stoner and Dr. C. E. James. Presentations of the pins were made by Dr. C. A. Gustafson, Youngstown, Councilor of the Association's Sixth District.

The scientific program consisted of a Cancer Symposium conducted by the following team from Ohio State University College of Medicine: Dr.

Edwin Ellison, associate professor of surgery; Dr. Luther Keith, assistant professor of surgery; Dr. Jack Widrich, associate professor of radiology; and Dr. Arthur G. James, associate professor of surgery and oncology.

The Secretary reported that the Postgraduate Assembly held at the St. Francis Hotel, Canton, on October 28 was a great success with 300 doctors in attendance. The committee in charge of this program consisted of: Drs. Lee Underwood, chairman; L. B. Schumaker, Scott Hill, Norman Lewis and D. Max Haas.

"The Problem of the A. W. O. L. Patient in Tuberculosis Control in Stark County," was the subject discussed by Dr. Ralph E. Dwork, chief of the Division of Tuberculosis of the Ohio Department of Health, at a special November 19 meeting of the Society.

A panel discussion followed, with the following persons taking part: Dr. John Dougherty, member of the Public Health Committee, County Society; Mr. L. L. Taylor, executive secretary, Stark County TB and Health Association; Dr. Constantine Vysniauskas, staff physician, Molly Stark Hospital; Dr. P. L. Harris, Stark County health commissioner; Dr. N. A. Rubin, local physician, and Miss Helen Beck, director, Central Case Registry, Molly Stark Hospital.

SUMMIT

The Summit County Medical Society had as guest speaker at its November 3 meeting on the University of Akron campus Nathan Howard Gist, inspirational speaker and humorist.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

A meeting of the Belmont County Medical Society with the Auxiliary was held at the Belmont Hills Country Club on November 19. Speaker for the occasion was Dr. Russell C. Bond, Wheeling, W. Va., whose subject was "Management of the Erythroblastotic Infant." The meeting started at 4:30 in the afternoon followed by dinner.

TUSCARAWAS

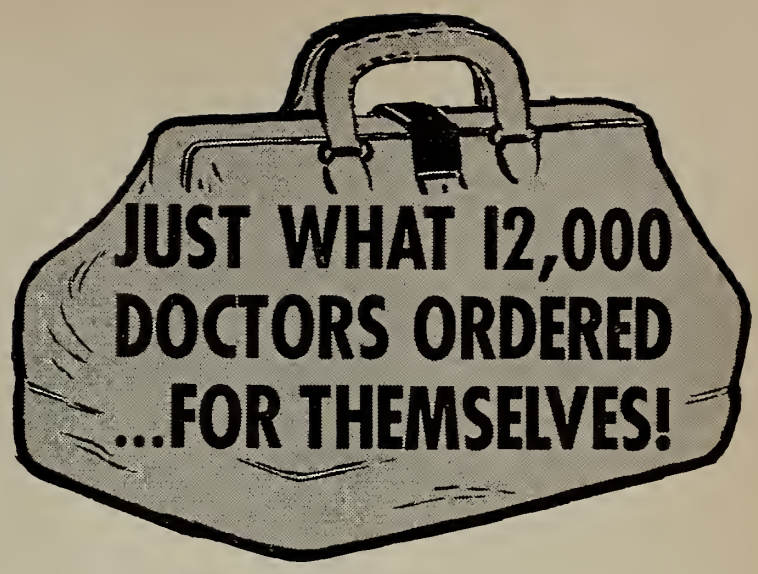
Dr. Max Miller, associate professor of medicine at Western Reserve University, spoke on the subject, "The Modern Treatment of Diabetic Acidosis," at the November 12 meeting of the Tuscarawas County Medical Society in Dover.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

LAWRENCE

Dr. W. W. Lynd, Ironton, was honored at a dinner meeting of the Lawrence County Medical Society on October 22, when he was presented the 50-Year Pin and Certificate of the Ohio State

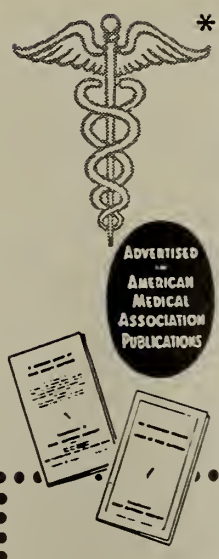




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Medical Association. Dr. C. L. Pitcher, Portsmouth, Councilor of the Ninth District, made the presentation in behalf of the Association.

A native of Ironton, Dr. Lynd has served all of his professional career there with the exception of a short time in the West.

SCIOTO

Dr. Raymond Bobbitt, Huntington, W. Va., spoke on the topic, "Problems and Management of Calculus Diseases of the Urinary Tract," at the November 9 meeting of the Scioto County Medical Society in Portsmouth.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held on November 10 at the Spring Valley Country Club, Elyria with dinner.

A business meeting was followed by an address by Dr. Ray A. Van Ommen, Cleveland, on the subject, "Treatment and Prophylaxis of Subacute Bacterial Endocarditis."

RICHLAND

Approximately 55 members of the Richland County Medical Society attended the regular meeting on October 15 at the Westbrook Country Club in Mansfield.

The speaker on this occasion was E. Perry McCullagh, head of the Section on Endocrinology and Metabolism at Cleveland Clinic. His subject was "Testicular Physiology and Infertility."

Columbus Health and Safety Center Is Dedicated

The new Columbus Health and Safety Center, a million-dollar structure, was dedicated with ceremonies on October 18, although it had been in use since the Spring.

In addition to housing the Columbus Health Department administrative offices, the building includes tuberculosis, venereal disease and dental clinics, the Columbus and Franklin County Chapter of the Foundation for Infantile Paralysis, a children's clinic, Columbus and Franklin County Civil Defense headquarters, laboratories for meats, restaurant and milk inspectors, offices for the Smoke Control and Vital Statistics Divisions.

The structure, situated on a 3.4 acre plot is constructed to permit additions of a south wing and a third story.

Taking part in the dedicatory ceremonies were Dr. Hamilton B. G. Robinson, president of the Columbus Board of Health; Dr. John D. Porterfield, director of the Ohio Department of Health; Representative John M. Vorys, Columbus, principal speaker; Dr. Charles A. Doan, dean of the O. S. U. College of Medicine; and Dr. Ollie M. Goodloe, Columbus health commissioner. Approximately 750 persons attended.



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1. Reich, C., and Mulinos, M. G., Treatment of Refractory Nutritional Anemia with Gelatine. Bull. N.Y. Med. Coll. March 1953.

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Activities of Woman's Auxiliary . . .

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President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House

Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima

Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

Congratulations to the newly organized Van Wert County Auxiliary and to its new president, Mrs. F. A. McCammon.

American Medical Education Foundation: Mrs. George W. Cooperrider, Ohio State Auxiliary chairman, reports contributions to the Foundation from eleven counties this year. They are: Miami, Clinton, Union, Pickaway, Summit, Clark, Ross, Marion, Delaware, Shelby, Lawrence.

AUGLAIZE

The Auxiliary met in September at the home of Mrs. Robert Herman in Wapakoneta. The meeting was called to order by the president, Mrs. David Nielsen, and the programs for the year were distributed. *Today's Health* is to be stressed during the year. Mrs. Guy Noble was welcomed into the group as a new member.

Following the business meeting, an interesting hour was spent observing a motion picture in color of the 30 old homes and surrounding formal gardens in Natchez, Mississippi, which were visited by Dr. and Mrs. Nielsen. The pictures were accompanied by commentaries by Mrs. Nielsen.

The October meeting of the Auxiliary was held in the home of Mrs. Edward White of St. Mary's, Ohio. The meeting was called to order by the vice-president, Mrs. Margaret Will, in the absence of Mrs. David Nielsen, who was ill.

The proposed levy for the reconstruction of the District Tuberculosis Hospital was discussed, and the entire program was endorsed unanimously by the Auxiliary. It was announced by Mrs. Guy Noble that plans for the St. Mary's Memorial Hospital Guild are underway, and that the wives of the dentists in the county are participating.

The cancer program in the county was discussed, and it was agreed that as soon as the program was established, the auxiliary would give it full support. A social hour of cards followed the business meeting.

BUTLER

Members of the Butler County Auxiliary from Middletown and Hamilton met for a luncheon and business meeting in Forest Hills Country Club in October. In charge of arrangements were Mesdames John Bauer, Walter Reese, Marion Swisher, and Martin Decker. Reports of the horse show were given.

CHAMPAIGN

The Auxiliary held its November meeting in the Millner's Colonial Room. Mrs. I. Miller conducted the meeting in the absence of the president, Mrs. R. E. Lowry. Mrs. A. B. Ream spoke on "Election Day Issues." The following committee was appointed for the Christmas party: Dr. and Mrs. F. E. Lowry, Dr. and Mrs. Lewis Inskeep, Dr. and Mrs. F. R. Grogan, Dr. and Mrs. D. H. Moore, Dr. and Mrs. A. B. Ream, and Dr. and Mrs. V. G. Wolfe.

CLINTON

A benefit bridge was held in the General Denver Hotel on October 20th. The committee in charge, included Mrs. J. H. Frame, Mrs. Arthur F. Lippert, Mrs. Ray D. Goodwin, and Mrs. R. H. Vance.

Mrs. H. Richard Bath, the president, conducted the November meeting held in her home.



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APPROVED: *by The American College of Surgeons*

Other officers are: Mrs. Arthur F. Lippert, president-elect; Mrs. R. R. Buchanan, vice-president; Mrs. John K. Williams, secretary; Mrs. R. H. Vance, treasurer; Mrs. William L. Wead, historian, Mrs. Wead was appointed as the group representative to the County Health Council.

CUYAHOGA

Mrs. N. M. Reiff, of Washington Court House, the State Auxiliary president, was introduced to the membership at the October meeting held in the Halle Lounge. Dr. John Budd, president of the Cleveland Academy of Medicine was a guest. Movies taken in Corsica by Dr. George Crile, jr., and his wife were shown. Mrs. Charles Abert, the president, conducted the meeting and announced the goals for the year.

DELAWARE

Mrs. E. C. Jenkins, the president conducted the October meeting when Dr. Ronald Greene, professor of psychology at the Ohio Wesleyan University, addressed the group, which met at the home of Mrs. C. B. Theiss. The subject was "Mental Health." Two new chairmen were appointed: Mrs. Tennyson Williams, mental health, and Mrs. Donald Gantt, civil defense.

Mrs. George Cooperrider, Columbus, National Medical Auxiliary program chairman, and Ohio State chairman of the American Medical Education Foundation, was guest speaker on November 3 at a four-county Medical Auxiliary luncheon at Bun's Restaurant. Delaware, Knox, Morrow, and Union counties were represented. Mrs. Cooperrider discussed the national, state, district, and county levels of "Our Auxiliary."

The luncheon and program were arranged by the Union County Medical Auxiliary.

Another state officer, Mrs. O. W. Jepson, Canal Winchester, co-chairman of the Ohio State organization committee and vice-president of her Auxiliary, spoke briefly. Mrs. E. J. Marsh, Broadway, district director, told of the importance of individual participation in the medical auxiliary.

ERIE

Mr. Walt Seifert, Columbus, was the guest speaker at the November meeting of the Auxiliary which met in the Business Women's Club. The hostesses were: Mrs. D. F. Sheldon, Mrs. C. F. Lavender, Mrs. R. Williamson, and Mrs. P. F. Southwick. Guests were Ed Farmer, Columbus; Sister Lucia, Sister Consalata, Mrs. Catherine Michel, and Mrs. William Williams.

FAIRFIELD

New student nurses of the Lancaster-Fairfield Hospital were entertained by the Auxiliary at the annual Autumn Party. Games and refreshments were arranged by Mrs. J. J. Hoodlett, assisted by Mesdames W. D. Monger, F. E.

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Spangler, W. D. Nusbaum, K. A. Gaines, A. C. Essman, and G. S. Rodabaugh.

Mrs. O. W. Jepson, vice-president of the State Auxiliary, entertained members of the Fairfield Auxiliary at the Shade Party House in Canal Winchester. Guest of Honor was Mrs. George Cooperrider, Columbus, National program committee chairman, who was introduced by Mrs. Fred Spangler. Top honors for bridge were awarded to Mrs. James Beasley, Mrs. J. L. Kraker, and in Canasta to Mrs. K. W. Taylor, Mrs. Spangler, and Mrs. Frederick W. James.

FRANKLIN

The Auxiliary was the first group to meet in the new Health and Safety Center, 181 Washington Blvd., Columbus. Dr. Ollie M. Goodloe, director of the Center, and Health Commissioner of Columbus, lectured on "Metropolitan Health." Mrs. Thomas R. Curran and Mrs. Ralph Johansmann arranged the program. Mrs. Harold Humphrey and the social and public relations committee served refreshments.

GREENE

Highlights of her trip around the world were reviewed by Mrs. Reed Madden when the Auxiliary met in her home in November. It was voted to make a contribution to the American Medical Education Foundation.

Tea was served during the social hour by Mrs. Richard F. Kelly of Xenia, auxiliary president, and Mrs. L. W. Sontag, Yellow Springs, a past-president. Hostesses were assisted by Mrs. A. D. DeHaven, Mrs. H. C. Messenger, and Mrs. Paul D. Espey.

HAMILTON

Mrs. Edgar H. White and Mrs. E. E. Rhodes were co-chairmen of the October meeting of the Auxiliary held at the Hyde Parke Country Club. Mrs. Robert Kottee, president, conducted a brief business meeting following luncheon. Mr. Theodore Wuerfel, chairman of the policy committee of the Children's International Summer Village, was moderator of a panel discussion of the village. Speakers on the panel were Judy Hilsinger, daughter of Dr. and Mrs. R. L. Hilsinger, member of the Swedish Village, Lewis Elsey, son of Dr. and Mrs. E. C. Elsey, member of the French Village, and Dick Frankel, son of Dr. and Mrs. Gilbert Frankel, member of the first children's Village, held in Glendale in 1951. Mrs. Hilsinger and Mrs. Elsey arranged the program for the day.

Mrs. J. J. Longacre, vice-chairman of the Program Committee for the Auxiliary was the chairman of the day for the second meeting of the year at the Cincinnati Club. The speaker of the day, Mr. Frederick A. Huack, president of the Continental Mineral Processing Corporation, was introduced to the group by Mrs. Longacre. His topic was "Mineral Sands for Our National Defense." The luncheon was followed

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by a meeting conducted by Mrs. Robert H. Kottee, president. Reservations for the luncheon were taken by Mrs. William C. Ahlering, Hospitality chairman of the day.

LAWRENCE

Mrs. W. F. Marting was hostess to the Auxiliary at her home on South Fifth Street. Mrs. Harry Nevni, the president, conducted the meeting. She gave a report of the Fall Conference held in Columbus. The group voted to endorse the Tuberculosis Levy, to give a gift subscription of *Today's Health* to each of the city and county high schools, and also voted to present a cash donation to the Medical Education Foundation.

LICKING

Mrs. K. D. Seiter reviewed William E. Barrett's latest novel, *The Shadows of the Images*, at the last meeting the Auxiliary had. The President, Mrs. Carl L. Petersilge, conducted the meeting. Mrs. R. G. Plummer, in charge of the November rummage sale, will be assisted by Mrs. Allen G. Crow, and Mrs. Carl Frye. Mrs. J. Y. Salzman reported on current legislation and urged the members to vote for the T. B. Sanitorium Levy.

LORAIN

Sister M. Theophane, the guest speaker at the October meeting of the Auxiliary, explained the practical nursing program at St. Joseph's Hospital, where she is the director of nursing service and director of the school for practical nursing. Mrs. Gerald Krupp, program chairman, introduced Sister M. Sebastin, administrator at St. Joseph's and a special guest at the meeting. Mrs. Theodore Finegan, Elyria, presided, at which time it was voted to support the American Medical Education Foundation and to support the visiting nurse program.

In September, members and their husbands enjoyed a "Moonlight Picnic" at the Dr. Robert Thomas farm in Elyria.

LUCAS

"The Live Issues of Today" afternoon and evening groups had a combined meeting at the Academy of Medicine Building. Hostesses for the meeting were Mesdames Howard Parkhurst, John Buck, Ned Hein, William Henry, Gordon Todd, and M. R. McGarvey. Mrs. Nelson Morris discussed "After Korea, What?" Mrs. John Buck and Mrs. McGarvey are co-chairmen of the afternoon group and Mrs. J. W. Mills and Mrs. Max Schnitker are co-chairmen of the evening group.

The Auxiliary was hostess to the visiting wives for the Northwestern Ohio Medical Association Scientific Assembly. There was a coffee hour in the Academy Building, and a luncheon in the Tally-Ho Tea Room with Dr. H. Keith Fischer of Temple Medical School as guest speaker. In the afternoon there was a punch hour. Mrs. Joseph Hertzberg was chairman of the women's

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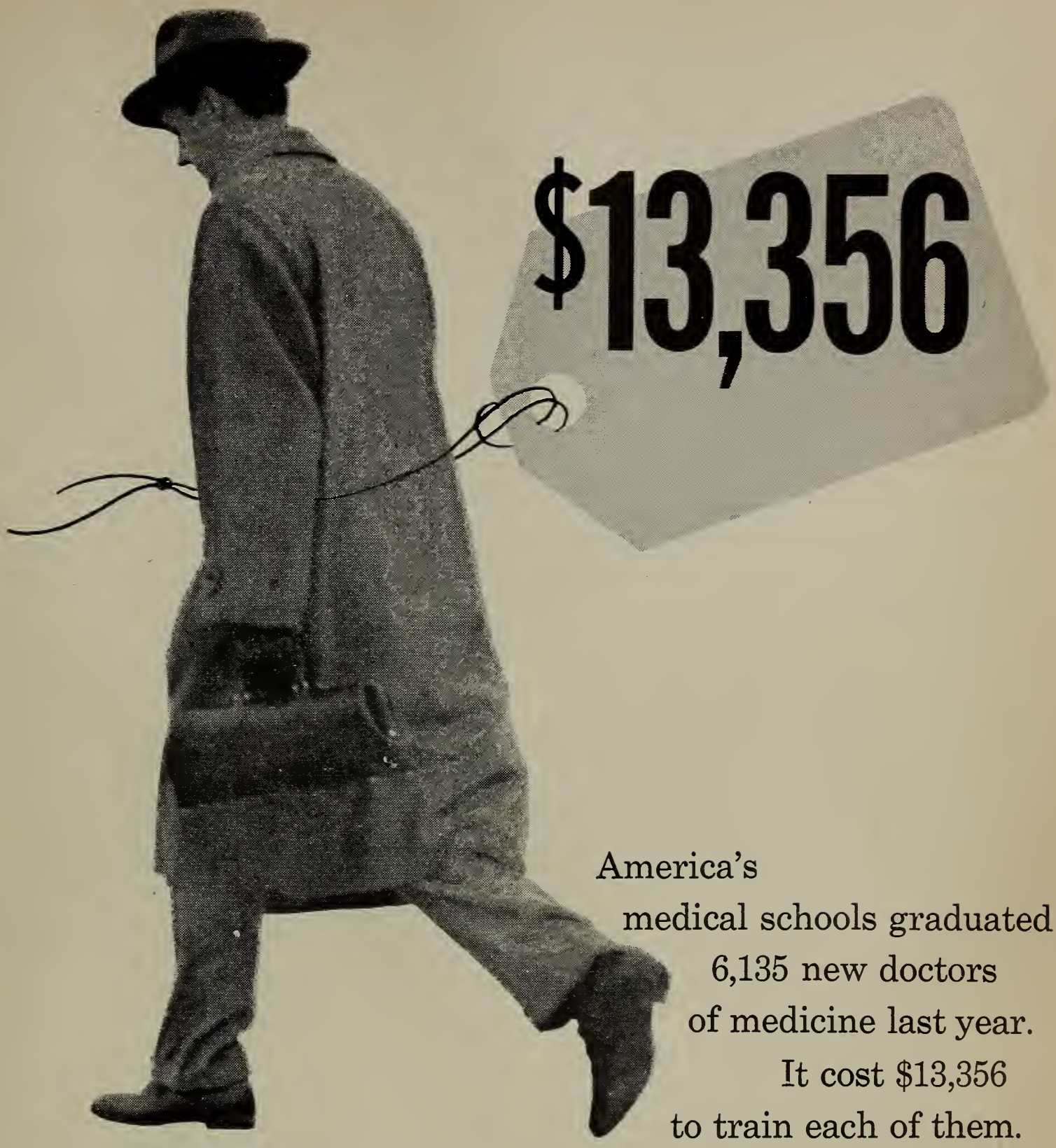
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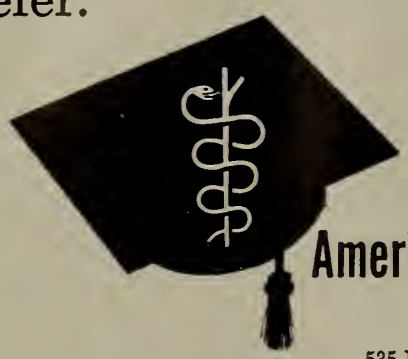
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activities committee. She was assisted by Mesdames Paul Bell, John Dickie, David Friedman, Emidio Gaspari, Wendell Green, E. Benjamin Gillette, F. V. Gipson, A. Paul Hancuff, Richard Hotz, George Lemon, Gustave Link, Edward McCormick, Myron Means, Fred Osgood, C. J. A. Paule, Kenneth Schoenrock, Merl Smith, O. H. Stone, Oliver Todd, E. Forrest Ward, jr., and A. D. Vogelsang.

The fund raising committee held the annual Hallowe'en Masquerade party in October. Mrs. Harold Shapiro and Mrs. J. B. Hirsch were co-chairmen. They were assisted by Mrs. F. V. Gipson, refreshment chairmen, with Mesdames E. F. Glow, F. R. Canelli, Howard Murphy, H. C. Weller, and Ernst Gottschalk; Fred M. Douglass, jr., chairman, and Kenneth C. McCarthy, Gorden Todd, A. Rees Klopfenstein, Leo Janis, J. D. Huss and David Levin, decorations; Ned B. Hein and W. H. Henry, prizes. Mrs. O. H. Stone, chairman, publicity and tickets, aided by Mesdames Henry D. Cook, Charles A. Phillips, Ralph A. Wickter, Henry Drake; and Mrs. Andrew A. Winter, reservations chairman, with Mrs. John W. Erkert.

Mrs. Henry Happle was hostess to the child development group in October. Mrs. William Phillips, group chairman, assisted her, and Mrs. Wendell Schlichting, leader, reviewed the booklet, "A Healthy Personality for Every Child" by Dr. Erick Erikson.

Members of the Mothers' March on Polio were entertained in the Toledo Women's Club. Mrs. Buck and Mrs. Hazen Hauman, chairman of the committee, were hostesses.

The library committee met with Matilda Muyskens, academy librarian. Mrs. E. Benjamin Gillette is chairman, assisted by Mesdames Henry A. Burstein, I. H. Kass, H. P. Lee, Ben Schulak, Maurice Schnitker, and A. S. Avery.

The Mental Hygiene Committee met in the home of Mrs. Henry Hartman. Dr. Anne Robbins, pediatrician, spoke on "Psychological aspects of the child in the home." The hostess was assisted by Mrs. William Phillips.

The opening meeting of the Auxiliary was held in the Academy Building. Mrs. Edward G. Haddad spoke on "The Treasures of the Orient," and was introduced by Mrs. Edward J. McCormick, wife of the president of the American Medical Association. Japanese kimonas were modelled by Mesdames C. R. Forrester, R. J. Borer, E. L. Gaspari, and J. M. Hertzberg.

MAHONING

An afternoon tea held in the Youngstown College Library marked the opening of the year for the Mahoning Auxiliary. Mrs. John Noll was the social chairman in charge of the party with Mrs. Frederick L. Schellhase in charge of the program. Mrs. Elmore McNeal is program chairman for the year. The newly organized members of the Corydon Palmer Dental Society were special guests. Mrs. W. O. Mermis showed Hawaiian color pictures and Miss Olive Burrows played piano music. Mrs. Ivan C. Smith, president-elect; Mrs. W. H. Evans, state chairman of nurses-loan and scholarship; Mrs. W. E. Maine, state chairman of radio and TV; and Mrs. Craig Wales, state chairman of civil defense, all attended the Fall Conference in Columbus.

The October meeting was a joint meeting with the Trumbull County Auxiliary held at the Squaw Creek Country Club. The social committee is headed by Mrs. Myron Steinberg, assisted by Mrs. Sidney Davidow, co-chairman, and Mrs. Andrew Detesco, Mrs. M. C. Raupple, and Mrs. George Altman. Mrs. Paul Hancuff of Toledo, State Auxiliary president-elect, was a special guest at the meeting. Mrs. Herman Ipp gave a book review of *Mary Todd Lincoln* and the student nurse choir of Trumbull County Memorial Hospital in Warren, sang several selections during the afternoon. Presiding were Mrs. Morris Rosenblum, president of the Mahoning group and Mrs. M. J. Crow, Trumbull County Auxiliary president.

Hostesses for the annual fall frolic of the Auxiliary held a meeting at the home of the chairman, Mrs. B. I. Firestone. Mrs. Ivan C. Smith and Mrs. Alfred Cukerbaum are co-chairmen for the party, a benefit for the nurses' scholarship fund.

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MIAMI

Mrs. George McCullough and Mrs. G. J. Hance presided at the tea given by the Auxiliary at Troy Country Club for 119 county high school juniors and seniors, who expressed a preference in a nursing career. The tea was also given to promote an interest in the annual scholarship given each year by the group. The scholarship is an outright gift to each girl who after graduation serves in Miami County for at least a year. The alternative is repaying the funds. The 1952 and 1953 scholarship winners, who appeared in uniform were guests of honor at the tea. Mrs. Paul Foy greeted the students. Miss Edith McClelland, instructor of nursing arts at Good Samaritan Hospital in Dayton, gave an inspiring talk. Miss Leora Greiser, newly appointed superintendent of nurses at Dettmer Hospital, was a special guest.

The October meeting featured Mr. M. F. Thompson, administrator for the Dettmer Hospital in Troy, as the guest speaker. He explained the operation of the new hospital. Mrs. Deeter, presided at the business meeting following the speaker. A motion was made to send $25.00 to the American Medical Education Foundation.

RICHLAND

Mrs. F. J. Heringhaus was in charge of the program on civil defense at the November meeting of the Auxiliary at the Women's Club. She presented Ralph Turner, executive secretary of the Richland County Red Cross, who spoke briefly on Red Cross training classes in first aid and home nursing. He also showed a film entitled "First Aid for Atomic Burns." Hostesses for the luncheon which preceded the meeting were Mrs. W. Max Brown, Mrs. W. R. Roseberry, Mrs. Charles Curtiss, and Mrs. Joseph Seibert. Thirty-eight members were present. Mrs. P. A. Blackstone presided at the business session during which Mrs. W. S. Kingsboro of Shelby and Mrs. Burr Hathaway were received as new members.

Members of the Woman's Auxiliary were hostesses to the members of the Eleventh District Auxiliary at a luncheon meeting at Westbrook Country Club. State officers who attended the meeting were Mrs. N. M. Reiff, Washington Court House, president, who was guest speaker; Mrs. A. Paul Hancuff, Toledo, president-elect; Mrs. George Cooperrider, Columbus, American Medical Foundation fund chairman; and Mrs. C. H. Bell, Mansfield, program chairman. Mrs. J. L. Stevens, an honorary member of the group and a past state president, also attended. Mrs. R. D. Campbell, Eleventh District director, was general chairman in charge of plans for the affair, and she introduced the state officers. Members of the hospitality committee were Mrs. J. S. Hattery, Mrs. C. M. Quick, Mrs. Paul Lee, and Mrs. Frank Turnocky. Mrs. Wilmot Peirce and Mrs. Albert Voegele were in charge of registration.

Reports of activities in the various auxiliaries of the 11th district were given by the presidents as follows: Mrs. Lester G. Parker for Erie County; Mrs. R. F. Fasoli, Medina County; Mrs. T. H. Smith, Huron; and Mrs. P. A. Blackstone, Richland. The fifth county in the district, Lorain, was unrepresented.

ROSS

Mrs. F. W. Gallagher, Columbus, was a guest at the October meeting of the group, which was conducted by the president, Mrs. Nicholas Holmes. Selling *Today's Health* was voted as a project for the year, and it was decided to send $15.00 to the American Medical Education Foundation. The group will assist with the Hospital Guild Association's Rummage Sale.

SANDUSKY

The Auxiliary held its opening meeting of the season with a dinner at High Manor. Mrs. K. K. Grubaugh, Woodville, was welcomed as a new member.

Mrs. A. P. Newman, president of the group, conducted the business meeting. Plans were made for the members to assist in the opening of the new wing of Memorial Hospital scheduled for October 1 and 2. Mrs. Newman was named chairman of the hostesses, to conduct tours. Mesdames F. L. Moore, M. M. Riddell, C. K. Egger, C. J. Wolf were named on the committee in charge of arrangements for refreshments.

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Mrs. R. R. Wilson and Mrs. Newman were named program chairmen for the year.

Auxiliary officers are Mrs. Newman, president; Mrs. L. E. Drossel, vice-president; Mrs. W. J. Martin, secretary; and Mrs. E. C. Swint, treasurer.

The October meeting was held in the home of Mrs. Glen Walker in Woodville. Mrs. F. A. Visconti, legislation chairman, reported on current legislation, and Mrs. J. L. Curtin, Mental Health Clinic, gave a report on the North Central Mental Health Clinic in Tiffin. Mrs. C. G. Egger, Mrs. L. E. Drossel, and Mrs. K. K. Grubaugh assisted Mrs. Walker with refreshments.

STARK

The Auxiliary opened its season with a luncheon in Massilon Woman's Club. The event, a 25th birthday party, honored the group's past presidents and new members. Mrs. Roy H. Clunk, assisted by Mrs. J. S. Williams, co-chairman, was in charge. The program was planned by Mrs. Graydon Underwood and Mrs. John R. Rohrbaugh.

Hostesses for the affair were Mesdames Robert Angerman, Thomas K. Ellis, Edward A. Hill, J. S. Klinge, F. P. Cuthbert, H. P. Hart, Merle K. Singer, and P. A. Paulson.

Mrs. A. Alvin Fisher presided at the meeting. Other new officers are Mrs. Herbert A. Jones, president-elect; Mrs. J. Sharp Wilson, vice-president; Mrs. C. V. Smith, recording secretary; Mrs. Raymond Saxen, corresponding secretary; Mrs. Cleon C. Couch, treasurer; and Mrs. L. B. Schumaker, assistant treasurer.

Committee chairmen for this year will be Mrs. Samuel J. Feingold, program; Mrs. Olin G. Wilson, membership; Mrs. Ned F. Bauhof, public relations; Mrs. Jack Yahraus, nurse scholarship and recruitment; Mrs. John R. Peffer, *Today's Health*; Mrs. C. H. Watson, radio and visual education; Mrs. James C. Hays, publicity; Mrs. Raymond S. Rosedale, legisation and parliamentarian; Mrs. Karl Lehmiller, telephone; Mrs. Ronald M. Harner, ways and means; Mrs. Francis C. Boyer, dance; Mrs. M. J. Hunyadi, historian, and Mrs. Homer I. Keck, civilian defense.

Climaxing the 25th anniversary celebration of the Auxiliary, Mrs. A. A. Fisher, current president, presented to Mrs. J. Edwin Purdy, the group's first president, a plaque in appreciation of her work. The event included a skit entitled "This is Our Life."

SUMMIT

At the October meeting of the Auxiliary, Leora Bevis, executive secretary of the Committee on Older Persons' Welfare Federation Agencies of Cleveland addressed the group. Her subject was "What is the Future of Our Older Citizens." Guests from the social agencies in the community were invited to attend the luncheon and lecture in the Akron City Club. Mrs. Norman E. Wentsler, the president, conducted the meeting. Mrs. Edmund R. Blower, vice-president and program chairman, introduced the speaker. Mrs. Walter H. Brown, social chairman, arranged the luncheon.

Mrs. Wilfreda Lytle, woman's coordinator for the Federal Defense Administration, spoke at the November meeting held in the Portage Country Club. Mrs. Lytle was introduced by Mrs. Blower.

TRUMBULL

The Trumbull County Auxiliary held a combined meeting with the Mahoning Auxiliary in October. Mrs. A. Paul Hancuff of Toledo, state president-elect, was the principal speaker. The Trumbull Memorial Hospital Nurses Chorus gave musical selections, and Mrs. Herman Ipp of Youngstown presented a book review on the life of Mary Lincoln.

TUSCARAWAS

The October meeting was held at the home of Mrs. Burrell Russell, New Philadelphia, with Mrs. H. F. Van Epps and Mrs. Henry Engel together with Mrs. B. A. Marquand as hostesses. Mrs. N. M. Reiff, state Auxiliary president, the speaker, discussed Auxiliary projects. Mrs. R. A. Wilson, the president, conducted the meeting. Mrs. Paul Doughten, legislation chairman, urged members to vote for the county health levy. Mrs. Henry Engel, a physician in her own right,



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and a native of Germany, gave a very interesting talk on Germany, its people, culture and literature, and industries.

The Seventh District meeting of the Auxiliary held in St. Clairsville was attended by many of the Tuscarawas group. Mrs. Van Epps of Dover is director of this district. Mrs. N. M. Reiff and Mrs. Paul Hancuff, state officers, attended.

WASHINGTON

Forty-three prospective nurses were entertained at a tea by the Auxiliary in the Marietta Memorial Hospital. Mrs. George Huston welcomed the students and a film, "This Way to Nursing," was shown. Miss Mary Ellen Roody, superintendent of Nurses, spoke and each guest was presented with a booklet prepared by the Bureau of Information of the Ohio State Nursing Association. Mrs. Huston was assisted by Mesdames Ford Eddy, Deane Northrup, Richard Hille, and Edgar Northrup. Other Auxiliary members who attended were Mesdames Donald S. Williams, S. E. Edwards, W. D. Turner, R. H. Sloan and Mrs. M. S. Muskat, president of the organization.

A benefit bridge was sponsored in the gymnasium of the Betsey Mills Club by the Auxiliary to raise funds for the Auxiliary projects in the Marietta Memorial Hospital. Preceding the event, prizes were wrapped by Mrs. Hille, Mrs. Deane Northrup, Mrs. Muskat and Mrs. George Huston at the home of Mrs. Williams, who was chairman of the benefit.

The Rev. Robert C. Martin, rector of St. Luke's Episcopal Church, spoke on the subject, "Provisions for Handicapped Children." The talk followed the dinner at the Betsey Mills Club. The Rev. Mr. Martin was introduced by Mrs. Edgar Northrup, program chairman. Mrs. Muskat conducted the business meeting. Committee's reports were given and Mrs. Donald S. Williams told of the success of the benefit bridge.

A contribution was made to the American Medical Education Foundation.

WYANDOT

An interesting talk was given by Dr. Donald Renwand, psychologist of the Sandusky Public Schools, at the October meeting of the Auxiliary in the Business Women's Club. Hallowe'en decorations were used, and the hostesses for the luncheon were Mrs. D. D. Lowe, Mrs. E. C. Alexander, and Mrs. H. L. Sowash.

General Physicians Hold Program in Cincinnati

The Southwestern Ohio Society of General Physicians in collaboration with the University of Cincinnati College of Medicine, sponsored a program on October 2 entitled, "Recent Advances in Therapy of Cardiovascular Diseases."

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* * *

DALLAS TO BE SCENE OF RURAL HEALTH CONFERENCE

Calling for all-out community "teamwork," the ninth National Conference on Rural Health will stress the importance of individual participation in community affairs at the March 4-6 sessions in the Baker Hotel, Dallas. Sponsored by the A. M. A.'s Council on Rural Health, the Conference theme will be: "Let's Put More 'U' In CommUNITY."

* * *

A. M. A. BOARD HAS ACTIVE SESSION IN CHICAGO

The A. M. A. Board of Trustees found plenty of hard work on the agenda when it met in Chicago at the headquarters building recently. In fact, there was so much work that the sessions ran well into the night.

The Board selected Chicago as the site for the 1956 meeting. It set the dates of June 11 to 15 for the annual session that year.

It approved the acceptance by Dr. Robert T. Stormont, secretary of the A. M. A. Council on Pharmacy and Chemistry, of an invitation to serve as a member of the World Health Organization's Expert Advisory Panel on the International Pharmacopeia and sub-committee for the selection of non-proprietary names for drugs.

The Board also approved the appointment of Frank Dickinson, head of the A. M. A. Bureau of Medical Economic Research, to serve as research consultant to the Human Resources Research Institute, Air Research and Development Command, U. S. Air Force, Maxwell Air Force Base, Alabama.

The Manpower Division of the Research Institute plans to prepare statistical reports which may be of use to the Air Force in establishing policies regarding its permanent force of officers, what types of persons should be appointed, how long they should serve in each classification and what should be done about those who are too old to continue flying. This study will involve the development of "working life" tables.

The Board approved the appointment of a Sub-committee on Alcoholism of the A. M. A. Committee on Mental Health. The action was taken after analysis of a field study of the alcoholism program in Buffalo and Erie County, New York.

The program was developed through the county medical society and has since been fully integrated with other community services, such as public and private hospitals, the departments of public health, the University of Buffalo School of Medicine, and the department of education in the western New York state area.

The Committee on Mental Health said it felt that this was the type of program which should be developed in other states and counties through state and county medical societies.

* * *

CHAMBER OF COMMERCE THINKING ON LEGISLATION

A. M. A. Assistant Secretary Bert Howard attended an important meeting of the Committee on Social Legislation of the U. S. Chamber of Commerce in Washington last week.

The committee, of which Dr. Howard is a member, reviewed the report on Federal-state relations before sending it to the Manion Commission on Inter-governmental Relations. The philosophy of the U. S. Chamber, with respect to the Federal grants-in-aid programs, is very similar to the policies expressed by the A. M. A. House of Delegates.

It is apparent that similar liaison should be established by constituent medical associations with state Chambers of Commerce. All of them have developed special committees to collect material that eventually will be gathered together by the U. S. Chamber of Commerce and forwarded to the Manion Commission.

Robison Named State Welfare Director As Lamneck Goes to Supreme Court

Shortly after announcing the appointment of Judge John H. Lamneck to the Ohio Supreme Court, Governor Frank J. Lausche advanced Judge Henry J. Robison, from assistant director to director of the Ohio State Department of Public Welfare.

Judge Lamneck was appointed state welfare director in January, 1949, after serving several years as Judge of the Common Pleas Court of Tuscarawas County. He had previously served a number of terms as judge of the Probate and Juvenile Courts of the same county.

The appointment puts Judge Robison in charge of one of the most extensive branches of the State Government. The Department of Public Welfare includes the Division of Mental Hygiene, headed by Dr. Lowell O. Dillon, which has charge of all state mental institutions. The Department also includes the Division of Corrections which supervises state penal institutions. The Division of Aid for the Aged and the Division of Social Administration are other branches which distribute state welfare funds and Federal grants for welfare purposes.

Judge Robison received his first Welfare Department appointment when he was named in 1936 as chief of the Division of Social Administration, although he had previously served on the Ohio Welfare Conference and on the Ohio Commission for the Blind. He had been Portage County Probate Court Judge from 1923 until his appointment. He has been assistant director of the Department since January, 1949.

Crile V. A. Hospital Needs Physician

Crile Veterans Administration Hospital is in need of a full-time or part-time admitting physician, according to Dr. Leon Ross, chief of professional services. Salaries commence at $5,940 and range to $9,600 with 25 per cent extra for Board certification. Quarters are available for a full-time physician at reasonable rental. Those interested may write or phone Dr. Ross, at the hospital, 7300 York Rd., Cleveland 29; VIctory 3-9260, Ext. 259.

Chest Physicians Announce Two Courses

The Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor courses in New Orleans, La., February 15-19, and in Philadelphia, Pa., March 15-19.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

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WANTED: Thoroughly-qualified physician for general practice and industrial work. 200 Republic Bldg., Cleveland, Ohio.

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WANTED PSYCHIATRIST-DIRECTOR for established Guidance Center providing Consultation, Diagnostic and Treatment services for children and adults. Staff includes 2 psychologists, 2 psychiatric social workers, 2 clerical workers. Salary $12,000. Plus private practice. Apply: Executive Secretary, Miami County Mental Health Assn., 600 Caldwell St., Piqua, Ohio.

WANTED: Physician, male, under 65. Must be U. S. citizen with Ohio license. Hospital for mentally deficient. New house and maintenance available. Salary $8,280. Gallipolis State Institute, Gallipolis, Ohio.

GENERAL PRACTICE AVAILABLE JAN. 1, 1954: Active, well-established practice plus complete office furnishings and equipment for sale or terms. Specializing. Cleveland, Ohio—East side. Box 754, c/o Ohio State Medical Journal.

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USED OFFICE EQUIPMENT for sale. Inquire L. J. Zupp, M. D., Huron Road Hospital, Cleveland 12, Ohio.

Dermatologists To Meet In Chicago

The 12th annual meeting of the American Academy of Dermatology and Syphilology will be held December 5 to 10 in the Palmer House, Chicago.

Basic courses will be held on histopathology, mycology, x-ray and radium, bacteriology and virology of the skin, anatomy and embryology, special problems in dermatohistopathology and research methods in dermatology. These courses will have a faculty of national reputation.

In addition the program will include lectures, panels, symposia and informal discussion groups.

ASSOCIATE WANTED: Well-trained young American doctor to share a well-equipped office and large general practice of office and hospital work. Should have hospital credits to get general practice privileges in hospitals here. Will introduce to clientele. No money needed. Write qualifications to P. O. Box 743, Akron 9, Ohio.

FOR RENT: Five-room office space in physician's Building, 63 North 4th St., downtown Newark; private parking, elevator service; heat furnished; building occupied by physicians and dentists only; rent reasonable. Jesse J. Hedges, West Village Drive, Newark, Ohio; Phone 6216.

American Academy of General Practice To Meet in Cleveland

The American Academy of General Practice will hold its sixth annual scientific assembly March 22-25 in the Public Auditorium, Cleveland.

Dr. Edward J. McCormick, Toledo, President of the American Medical Association, will be a featured speaker as will such other top flight men as Sir Alexander Fleming and Dr. Howard Rusk. Details of the program will be announced later.

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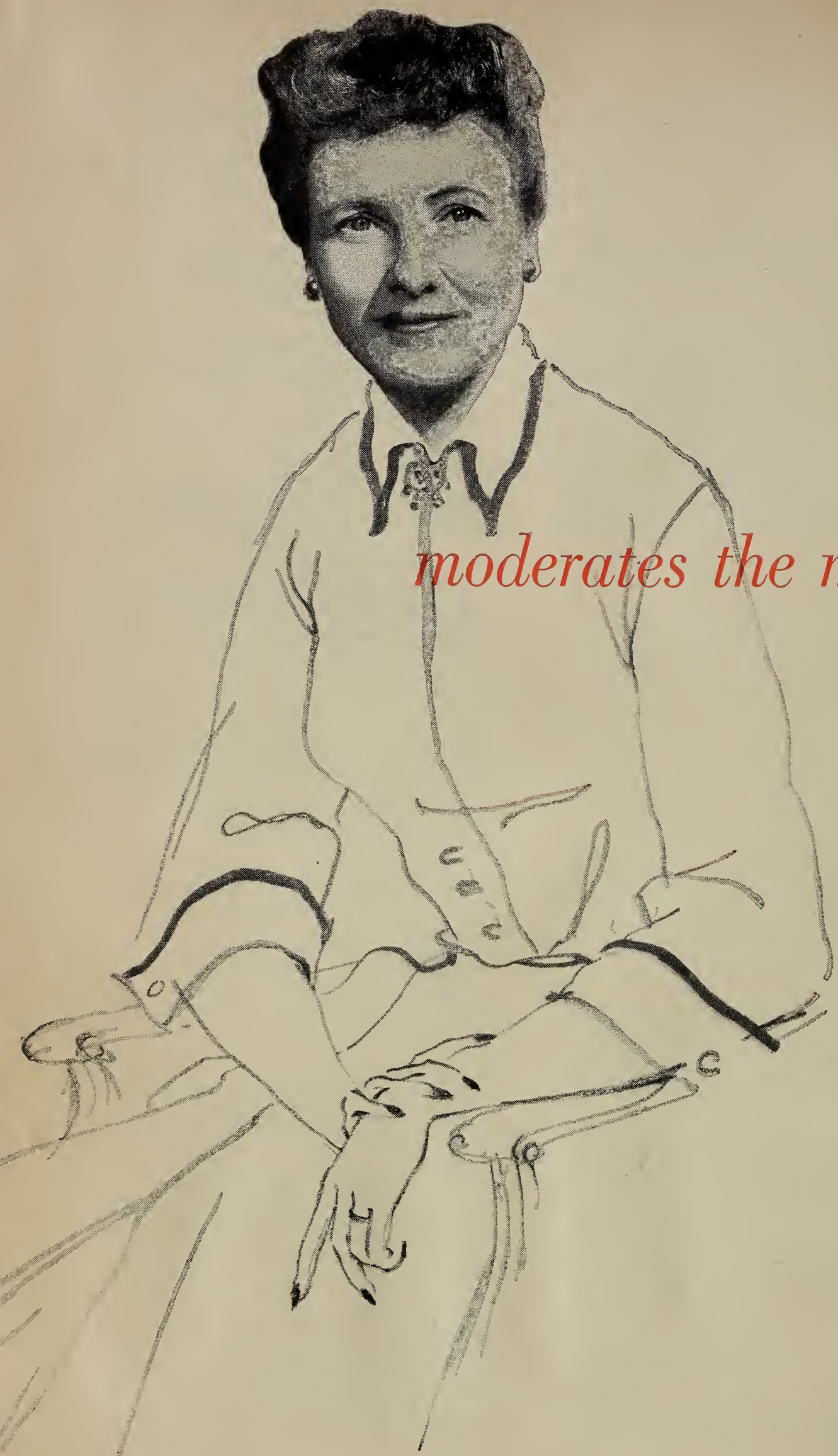
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